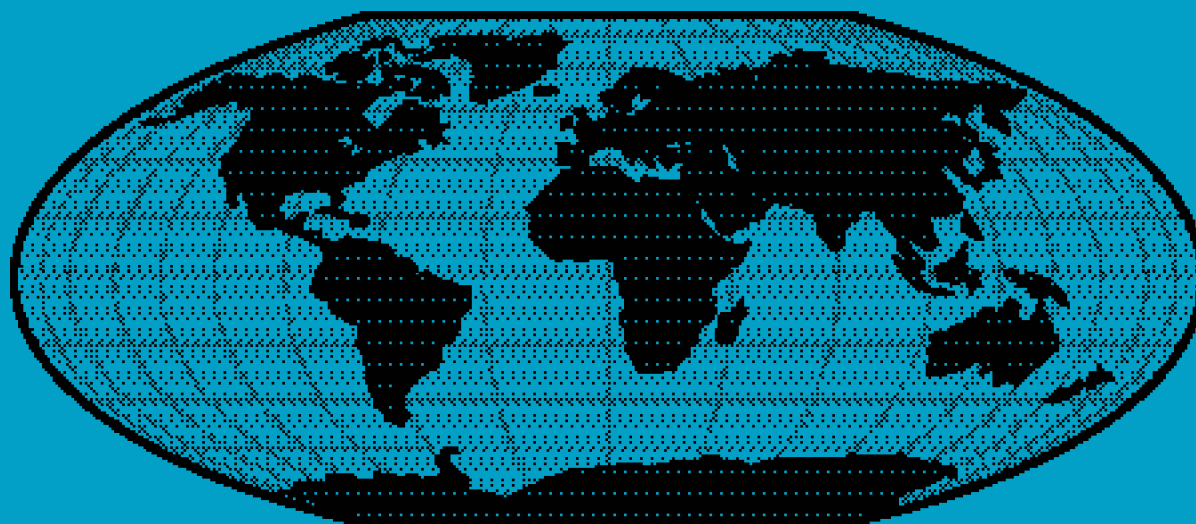




Operations Research and Technical Assistance



Improving Family Planning and Reproductive Health
Services Worldwide



OPERATIONS RESEARCH AND TECHNICAL ASSISTANCE

What is Operations Research?

Operations Research (OR) is a problem-solving process used to improve the accessibility, availability, quality and sustainability of family planning and reproductive health service delivery. OR consists of five basic steps: 1) problem identification and diagnosis; 2) strategy selection; 3) strategy experimentation and evaluation; 4) information dissemination; and 5) utilization of results. An important objective of OR is to provide program managers and policy decision-makers with the information they need to improve existing services and plan for the future.

Since the inception of the USAID-funded “Strategies for Improving Service Delivery: Operations Research/Technical Assistance Project” in 1974, field-based research studies have been experimentally testing and evaluating innovative ways to deliver family planning and reproductive health services in developing countries. Increasingly, issues of gender, empowerment, and reproductive health for men and women throughout their lives, affect the way in which service delivery problems are defined and solutions developed.

The Population Council collaborates with local partners in supporting operations research and technical assistance in Africa, Asia and the Near East, and Latin America and the Caribbean.

Operations Research Summaries present key results from worldwide OR/TA projects supported by the Population Council and other collaborating agencies. Each summary is identified by theme and country. **OR Summaries** are organized by themes as follows:

- **Maximizing Access and Quality of Care (MAQ)**
 - **Access**
 - **Quality of Care**
 - **Situation Analysis**
- **Contraceptive Options**
- **Postabortion Care**
- **RTIs, STIs, HIV/AIDS**
- **Gender and Empowerment**
- **Youth**
- **Cost and Sustainability**
- **Institutionalization of OR**

This series is produced in English, French and Spanish and distributed to key policy decision makers and program managers worldwide.



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ACCESS



Fran Antmann (Unicef)

Access and quality are critical dimensions of reproductive health programs. Program managers and policy makers often consider them together in plans to strengthen service delivery. **Access** refers to the degree of difficulty a client encounters in obtaining services. Barriers to access include the distance a client has to travel to reach services, the costs of services, the attitudes of providers, and unnecessary eligibility requirements that exclude clients based on age, marital status, or gender.

Operations research on **access** to services has focused on measuring access; testing new service mechanisms, such as community-based distribution programs; improving the performance of volunteer health workers; and developing private sector family planning programs.



BILINGUAL PRIMARY TEACHERS EDUCATE INDIGENOUS GUATEMALAN AUDIENCES IN REPRODUCTIVE HEALTH

The Guatemalan Association for Sexual Education (AGES) trained bilingual teachers to conduct reproductive health classes. As a result, contraceptive use in the participating communities rose by 3 percentage points within six months of course completion.

BACKGROUND

The Mayan population, 40 percent of the total population in Guatemala, has a contraceptive prevalence rate of 10 percent, one-fourth of the national figure. Studies have shown that Mayan men and women are aware of the deleterious effects of having too many children and having children too closely spaced. However, they have only limited knowledge of contraception and of contraceptive sources. One of the main obstacles for providing RH information and services is the lack of service providers who can speak indigenous languages. Traditionally, agencies in Guatemala have tried to provide family planning information in indigenous communities by training volunteers or having an outside agent carry out activities in the communities. Both systems have failed.

This project, carried out by the Guatemalan Association for Sexual Education (AGES), with technical assistance from the Population Council's INOPAL Project, tested using teachers from the National Bilingual Education Program (PRONEBI) to teach reproductive health courses in indigenous communities. AGES developed three 10-hour courses. Topics included birth spacing; pregnancy, birth and gender; and mother and baby care. PRONEBI teachers wishing to participate in the Reproductive Health Education System had to pass a written examination based on a list of readings, and attend a 12-hour training course for each module. Teachers who completed certification assembled groups and taught courses in their communities. At the end of the course, they were paid 125 quetzales (US \$22) for each 10-hour course taught.

FINDINGS

□ A total of 56 teachers completed the training process and taught at least one course in an indigenous community.

□ During a seven month period, trained teachers taught a total of 496 courses to 11,171 persons.

Participant Responses After Taking the Course

"Now I am going to plan my family."

"I learned about the sexual parts and functions of men and women."

"I learned how our body changes and how a child is born and grows."

"I learned to improve communication with my partner."

"I learned to value my wife and children."

Source: Cospín et al., 1997

- The contraceptive prevalence rate among married women of reproductive age increased by at least three percentage points after the course (equivalent to a relative increase of 18 percent in the use of all methods, and of 40 percent in the use of modern methods).
- A follow-up survey showed that participants liked the course. Communication between partners on sexuality seems to have been enhanced.
- Sixty-five percent of the participants not in union, and those married but not yet using methods, said they expected to use a family planning method in the near future.
- The cost per course was US \$56.40, and per student US \$2.50.

Implication of Findings

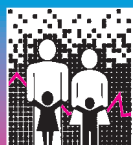
- The Reproductive Health Education System tested was effective in screening out unmotivated teachers or teachers who do not have the learning skills who do not have the learning skills needed to participate effectively in the system. In addition, the project showed that PRONEBI teachers can do much of the studying by themselves, thus greatly reducing training expenses.

UTILIZATION OF THE RESULTS

- AGES is now in the process of securing funding from different sources to continue using this educational strategy, not only for family planning purposes, but also for other topics such as environmental protection, nutrition and women's rights.
- AGES has begun a new project which uses PRONEBI staff to distribute family planning methods in addition to teaching reproductive health classes.

Cospín, Gloria and Ricardo Vernon. 1997. Reproductive Health Education in Indigenous Areas Through Bilingual Teachers in Guatemala. Guatemala City: Asociación Guatemalteca de Educación Sexual y Desarrollo Humano (AGES) and the Population Council. April.
For more information or to receive a copy of this report, please contact Ricardo Vernon, Deputy Director, INOPAL III, Population Council. Escondida 110, Col. Villa Coyoacan, 04000, Mexico, D.F., Mexico, Tel: 52-5-659-8541, Fax: 52-5-554-1226, E-mail: rvernon@laneta.apc.org.

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CBD PROGRAM USES DAIRY COOPERATIVES TO INCREASE FP ACCESS AND ACCEPTANCE

A community-based distribution (CBD) program in India's rural Bihar State provided family planning and maternal and child health (FP/MCH) services to members of dairy cooperatives at work and in their homes. The program improved access to services, expanded the choice of available methods, and increased members' knowledge of family planning and acceptance of contraception.

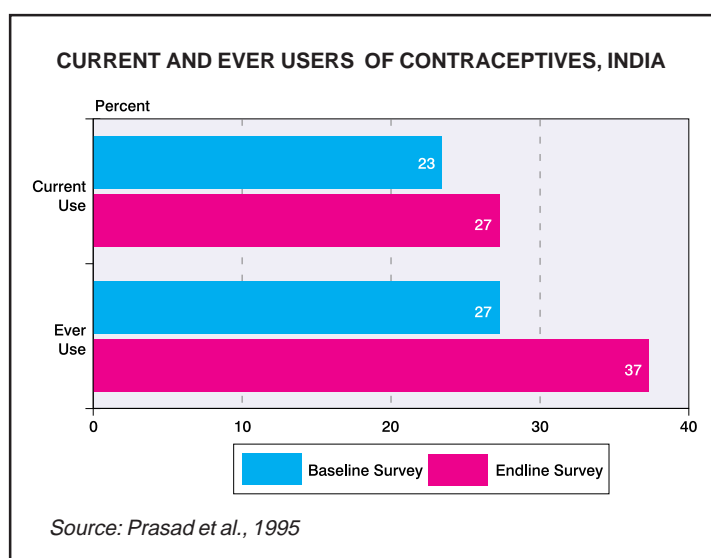
BACKGROUND

This study documents the results of the Rural Family Health Project implemented in Samastipur District by the Bihar State Cooperative Milk Producers Federation (COMPFED) in collaboration with the Center for Development and Population Activities (CEDPA). The three-year project tested whether improving the access of dairy cooperative members to family planning services at the work site and at home, providing an expanded choice of contraceptive methods, particularly temporary methods, and providing follow-up care would increase their knowledge of family planning and acceptance of contraception. The Population Research Center conducted baseline and endline surveys with 2500 randomly selected households spread over 40 Dairy Cooperative Societies (DCS) in 63 villages. The study's qualitative component, conducted by the Institute of Psychological Research and Services, Patna University, focused on the project implementation process.

FINDINGS

□ The survey results show a substantial increase in ever users (10 percentage points) and a 3.6 point increase in current users. CPR increased from 23 to 27 percent. The increase in ever users was mainly due to acceptance and later discontinuation of pills.

□ Although knowledge of all contraceptive methods increased with the CBD approach, about half of eligible women still did not know how to use temporary methods correctly at the end of the project. Misconceptions about all methods except pills declined.



- The high unmet need (31 percent) for contraception did not decline. Qualitative data showed that 52 percent of pregnancies and 23 percent of births in the lifespan of women aged 15 to 45 years were unwanted.
- Commercial sources for contraceptive methods in the project area are limited. In many villages, the project's Voluntary Health Worker (VHW) was the only local source for condoms and pills. Easier access to contraceptives and the availability of a VHW within the community encouraged some women to adopt family planning even without the knowledge of their husbands or mothers-in-law.
- Wherever the VHWs were active and contacted the village women regularly, their acceptance of family planning increased. However, not all VHWs were active, and in many areas they could not visit homes because of social barriers.
- Opposition from husbands and in-laws, the desire for at least two sons, and lack of trust of VHWs from a different caste or religion were obstacles to acceptance of contraception.
- Potential VHWs should be provided with realistic information about the nature and scope of the job. Many were unprepared for the work's challenging nature. They need regular guidance, an evaluation system that measures quality in terms of providing more choices, and more detailed information about contraceptives.
- The project had a very positive impact on the life of the VHWs, resulting in enhanced self-esteem, an improved spousal relationship, and increased independence both inside and outside the home.
- Cost analysis showed that an investment of US\$8,695 was required for every unit of increase in CPR (in an area covering about 54,000 eligible women). The cost for reaching a new condom acceptor was US\$10 and a new oral pill acceptor, US\$15. The cost of one Couple Year of Protection for female sterilization was between US\$8 and \$10.

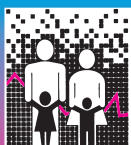
UTILIZATION OF RESULTS

- The COMPFED model is being replicated in Uttar Pradesh under the Innovations in Family Planning Services Project (IFPS) with modifications based on the lessons learned in Bihar. Modifications include more comprehensive training for VHWs and outreach activities to family members, particularly husbands and mothers-in-law.
- The Bihar project has been extended in order to study the dynamics of sustainability and costs in the model, with the objective of applying the lessons learned to projects elsewhere in India. In order to make the FP and MCH services more sustainable, Dairy Cooperative Societies need to contribute toward the cost of maintaining them and assume responsibility for program management.

Prasad Rudranand, Ram Bachan Ram, M.E. Khan, Bella C. Patel. 1995. Promotion of FP/MCH Care Through Dairy Cooperatives in Rural Bihar. New Delhi: Population Research Centre (Patna), Institute of Psychological Research and Services (Patna) and the Population Council.

For further information on this study or to obtain a copy of the final report, please contact the Population Research Centre, Patna University, Patna, Bihar. Tel: 0612-650017. Or the Population Council, 53 Lodhi Estate, New Delhi 110 003, India. Tel: 91-11-461-0913/461-0914, Fax: 91-11-461-0912.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.



MEASURING THE IMPACT OF COMMUNITY-BASED DISTRIBUTION PROGRAMS

CBD programs in Kenya are effective sources of FP information, and many provide a significant proportion of contraceptive supplies to users, particularly women using pills. A strong supervisory system is a key determinant of CBD agent performance.

BACKGROUND

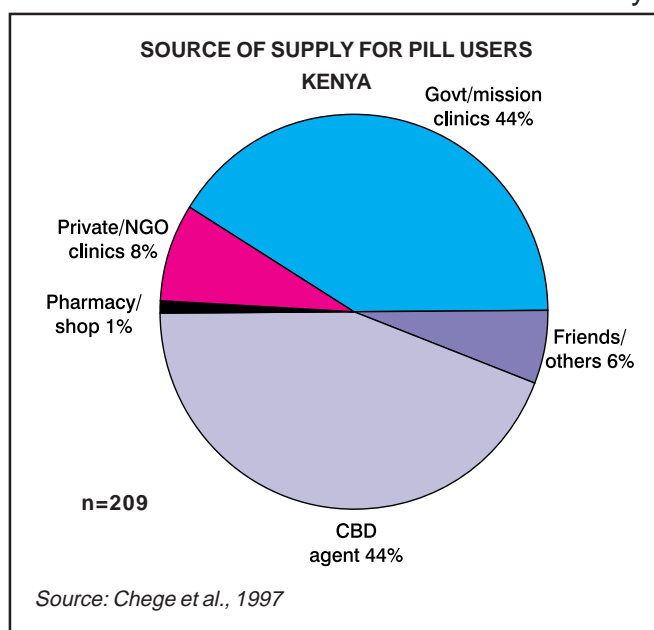
Kenya is one of the leading countries in Africa in developing and implementing community-based programs as part of the national family planning program. Virtually every approach to CBD that has been tried somewhere in the world is represented in Kenya. The Population Council's Africa OR/TA Project undertook an evaluative study of seven of Kenya's largest CBD programs (four rural and three urban) to determine the effectiveness, cost-effectiveness and performance of the different approaches for use in guiding program planning and future resource allocations. Study methodologies included catchment area questionnaire surveys; in-depth interviews with CBD agents, supervisors and managers; and a review of program service statistics. The study also assessed the degree to which the programs met other reproductive and sexual health needs, addressed gender concerns, and provided other basic health services.

FINDINGS

□ One-half of men and women interviewed in the catchment areas said they knew of a CBD agent; these proportions were higher for rural programs.

□ Among women who use contraceptive pills, 44 percent get their method from an agent. Among women who use a supply method (i.e. a method for which a source of supply is needed), 40 percent obtain their method from a CBD agent. Over one-third of male condom users get their method from an agent.

□ Among current contraceptive users, CBD agents were cited as the method source for 16 percent and 19 percent of all female and male users respectively.



- Almost 80 percent of CBD clients said the agent discussed methods other than the one they chose and told them they could change methods if they wanted.
- Overall, the CBD agent was the source of most information about family planning for 12 percent of women and 11 percent of men interviewed. Among their clients, however, over half said the agent was their main source of information.
- Three-quarters of the CBD agents interviewed said they would not provide contraceptives to a young woman who had never been pregnant, but less than one-fifth said they would not provide contraception to a young male, regardless of whether he had proven his fertility or not.
- The program with full-time, salaried agents had the highest average number of clients met per year and the greatest number of users. Other factors which appear to influence service output per agent include the level of FP demand within the catchment area and the quality of supervision.
- The four programs with the highest average outputs per CBD agent all require supervisors to have individual and group contacts with CBD agents on a monthly basis.
- The vast majority of clients said that they are satisfied with the quality of services CBD agents provide. However, all programs were weak in three areas: 1) discussing method side effects and how to manage them; 2) maintaining adequate contraceptive supplies; and 3) the technical competence of CBD agents.
- A female CBD agent's work in her community appears to provide an opportunity for self-enhancement, and increased autonomy and decision-making power, both within her own family and in the wider community.

UTILIZATION OF RESULTS

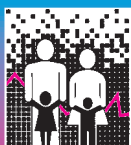
- National level policy makers, program managers, donors, and managers and staff from several programs have proposed numerous recommendations and made plans to take actions aimed at strengthening their programs.
- Other countries in the region, like Tanzania, are using the study approach as they seek ways of improving existing and developing new approaches to CBD programs.

Chege, Jane Njeri and Ian Askew. 1997. An Assessment of Community-based Family Planning Programmes in Kenya. Nairobi: the Population Council. January.

For more information or to obtain a copy of the report, please contact the Africa OR/TA Project II, Population Council, P.O. Box 17643, Nairobi, Kenya, Tel: (254)(2)713-480, Fax: (254)(2)713-479, E-mail: ORTA@popcouncil.or.ke.

This project was supported by the Population Council's Africa Operations Research and Technical Assistance Project II. The Africa OR/TA Project II is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-3030-C-00-3008-00, Project No 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

January 1998



VILLAGE-BASED WORKERS INCREASE WOMEN'S ACCESS TO FAMILY PLANNING

Village-based family planning workers in Pakistan have been successful in improving rural women's access to a range of family planning services. Planning for expansion of their duties to include more primary health care responsibilities has begun.

BACKGROUND

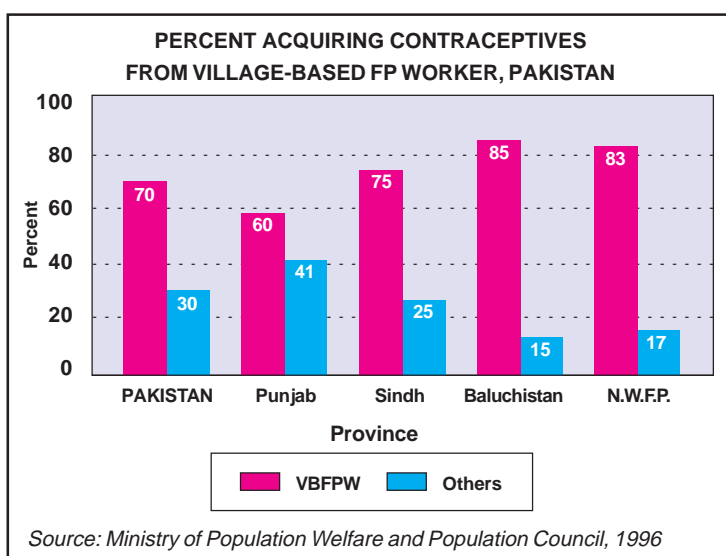
An objective of the Government of Pakistan's Eighth Five Year Plan is to expand access to family planning in rural areas from five to 70 percent by 1998. The Village-Based Family Planning Worker Scheme of the Ministry of Population Welfare (MPW) is the centerpiece of these efforts, and by 1997 the scheme is expected to deploy 12,000 Village-Based Family Planning Workers (VBFPW) to deliver family planning and health care services at the household level. Begun in 1992, the scheme is being undertaken at a time when the rural population is showing new signs of readiness to reduce traditionally high levels of childbearing. This Situation Analysis of the VBFPW Scheme examined how effectively the scheme was working after two and a half years of implementation. Data was collected on the activities of 211 VBFPWs through client and worker interviews, observation of worker visits, and inventory of the workers' family planning method supplies.

FINDINGS

□ The average VBFPW is a woman aged 28 with three living children. More than half had completed secondary education and nearly half were using some method of family planning. Most resided in their assigned villages.

□ More than 90 percent of woman interviewed reported overall satisfaction with VBFPW services, and the VBFPW was the source of contraceptives among 70 percent of contraceptive users.

□ Most clients reported being visited repeatedly by the VBFPW, and nearly three-fourths were visited at least once a month. Forty-five percent of those visited were current users of contraception, with another 14 percent having agreed to accept but not yet begun use.



- Eighty percent of users had been using family planning for less than one year. Pills and condoms were the most commonly used methods, but there were substantial numbers of users of IUDs, female sterilization and injectables.
- Thirty-two percent of the clients who did not want more children were not using a method. However, 36 percent who were using contraception wanted more children, indicating awareness of birth spacing.
- Nearly 90 percent of VBFPWs had served for more than one year, and about 46 percent had been serving for more than two years. About two-thirds reported that their social status had improved as a result of becoming a VBFPW.
- Discussion of side effects was the major outcome of 23 percent of visits, while general and health visits were the primary outcome of 21 percent. Eight percent of visits resulted in a method being accepted and 7 percent in a referral.
- About 63 percent of VBFPWs had completed registration of all eligible couples in their villages. However, only about 30 percent kept complete client information in their registers, and only about 20 percent kept their registers up-to-date. Few developed monthly work plans.
- Administrative support to VBFPWs from the Provincial Welfare Departments for supervision, supplies and salaries is variable. Supervisors had visited 59 percent of workers during the previous two months, though nearly all workers had visited their training center during the past month. Only 39 percent had received their previous month's salary.
- Contraceptive stocks were generally low, and 56 percent of VBFPWs had run out of some contraceptive stocks in the past six months.
- Fewer than half of VBFPWs had any information, education and communication (IEC) materials, and a worker used IEC materials in only one of the 814 visits observed.

UTILIZATION OF RESULTS

- The Situation Analysis findings on quality of VBFPW interaction with clients, the range of methods being provided, and client information on methods were the basis for a national VBFPW seminar in May 1996.
- The findings on the lack of IEC materials for VBFPWs led the MPW, in collaboration with the Council and UNFPA, to sponsor a strategy workshop to develop a complete set of IEC materials for the program, for training, reference, and counseling, as well as materials for clients. A comprehensive plan for preparation of materials and implementation has been approved.
- Further evaluation of VBFPW training is underway, with the goal of improving curricula, training of trainers and follow-up.

Ministry of Population Welfare and the Population Council. 1996. Situation Analysis of Village-Based Family Planning Workers. Islamabad. May.

For further information on this study or to obtain a copy of the final report, please contact: the Population Council, House No.55, Street No. 1, Sector F 6/3, Islamabad, Pakistan. Tel: 9251-277439, 827536, Fax: 9251-821401.

This project was conducted with support from the Population Welfare Department, Ministry of Population Welfare, Overseas Development Administration (UK), Asian Development Bank and the Population Council. The production of this research summary is supported by Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

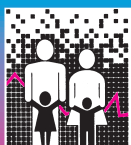
QUALITY OF CARE



Shari Kessler (ANE OR/TA Project)

Access and quality are critical dimensions of reproductive health programs. Program managers and policy makers often consider them together in plans to strengthen service delivery. Increasing access to family planning and reproductive health services does not necessarily guarantee the **quality** of the services provided. **Quality of care** consists of six elements: choice of methods, exchange of information, technical competence of providers, client-provider relations, continuity of care, and the appropriateness and acceptability of the services provided.

Operations research on **quality of care** has focused on measuring quality from both the clients' and providers' perspectives; testing mechanisms to integrate family planning with broader reproductive health services; and developing approaches to increase provider effectiveness through improved training and supervision.



MEASURING CHANGES IN FAMILY PLANNING SERVICES QUALITY OVER TIME

A comparison of the results of Situation Analysis (SA) studies carried out in 1992 and 1995 in Burkina Faso shows that rapid expansion of FP services nationwide resulted in both improvement and decline in selected elements of program functioning and quality of care. The comparison also provides information on the possible impact of interventions aimed at improving identified gaps in the system.

BACKGROUND

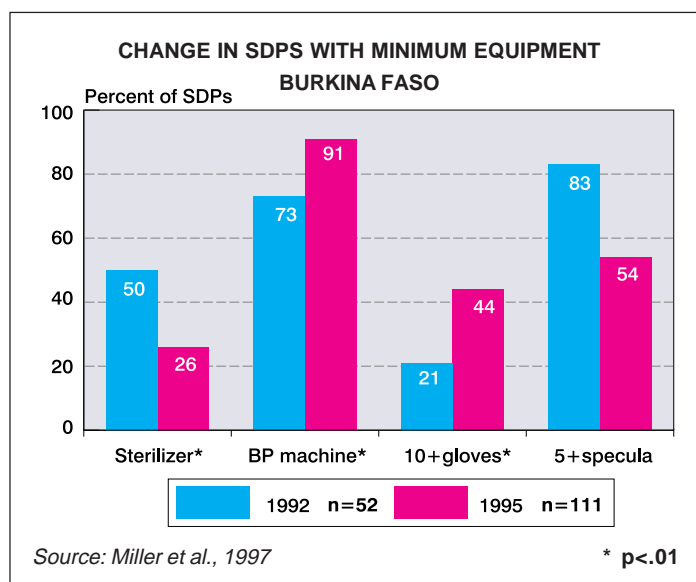
In 1992 the Burkina Faso Ministry of Health (MOH) conducted a first Situation Analysis, which included a census of 53 service delivery points (SDPs) in twelve regions, or about one-third of the SDPs offering family planning at the time. Following that study, FP services were rapidly expanded, and by 1995 had been introduced into 585 SDPs in all 30 provinces. In addition, the MOH and donor agencies carried out several interventions to improve services at both existing and new family planning SDPs. Interventions focused mainly on training but also on equipment, decentralization of services, and information, education and communication (IEC). In order to evaluate these services and interventions, the MOH undertook a second Situation Analysis in 1995. This study compares FP services at the 53 SDPs included in the 1992 Situation Analysis with the sample of 117 SDPs from the same regions in the 1995 study.

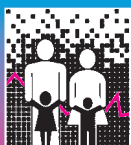
FINDINGS

Functional Capacity Indicators

□ The average amount of equipment available at SDPs did not change over time, but there were changes in supplies of specific items, such as a decline in sterilizers and specula and an increase in blood pressure (BP) machines and gloves.

□ Most SDPs have waiting rooms or toilets, and no decline occurred in the availability of these items between 1992 and 1995. The availability of satisfactory examining areas fell dramatically from 60 percent to 21 percent, mainly due to water shortages and problems with cleanliness.





CONTINUATION OF CONTRACEPTIVE AND SERVICE USE: THE CSI PROJECT EXPERIENCE

Three-fourths of Clinical Service Improvement (CSI) clients were still using a method of contraception four to five years after initial contact with CSI. However, only 17 percent continue to use CSI services after four years. A major reason for CSI clients switching their source of family planning supply was ease of access for follow-up services.

BACKGROUND

The Clinical Service Improvement project in Egypt has sought to develop a clientele of continuous contraceptive users. The client drop-out rate from CSI services is a cause for management concern, especially if accompanied by a break in contraceptive use. The Population Council sponsored a study conducted by the Cairo Demographic Center (CDC) to evaluate the effectiveness of the CSI project in achieving long term sustained use of contraceptives among its clients. The study interviewed 2,227 CSI clients about their contraceptive use since their initial contact with a CSI clinic four or five years ago. More than three-fourths of the enrolled clients were successfully contacted.

FINDINGS

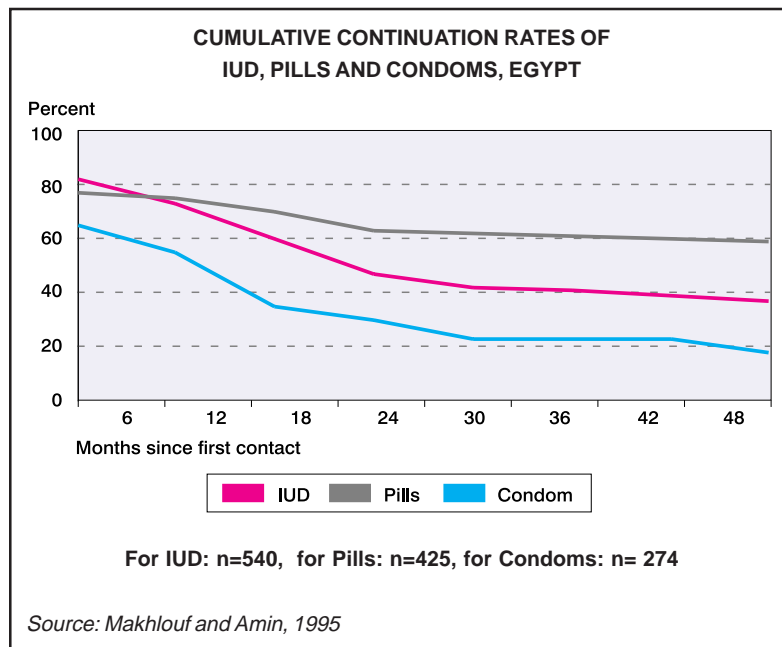
Lack of method continuity

□ CSI clients changed FP methods up to five times over the past four to five years; 62 percent of clients cited side effects as the reason for changing methods.

□ Injection and condom users switched more frequently to other methods and particularly to pills. IUD users by contrast were more stable. The IUD is the most commonly used method by CSI clients (65 percent).

Lack of continuity for source of method

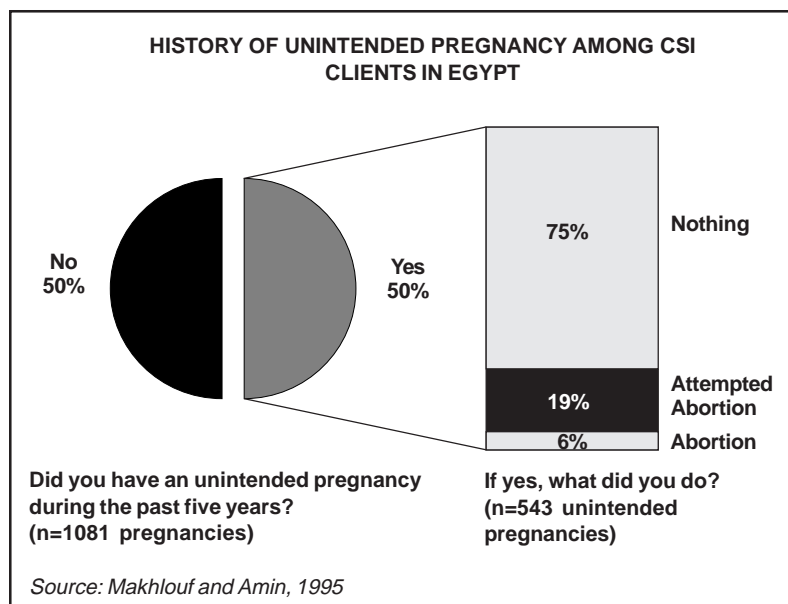
□ Although the entire sample began at a CSI clinic, only 17 percent continued to use CSI services for four or five years. Twenty-nine percent stopped using both a contraceptive method and CSI services. Of the 54 percent still using a contraceptive method but not using CSI services, 22 percent were using a long acting method and thus did not need to return to CSI.



□ Among CSI clients who changed to another source, the majority shifted to using pharmacies (45 percent) or private doctors (25 percent). The most common reasons for changing their source of method were the relative ease of access to the new source for follow-up services (70 percent), and the high cost of CSI services (12 percent).

Unintended pregnancies

□ The 2,227 women interviewed for this study experienced a total of 1,081 pregnancies during the past five years. Half of these pregnancies were reported to be unintentional, of which 31 percent occurred during a temporary period of non-use, and 19 percent were accidental during contraceptive use. Clients attempted to terminate, either with or without success, 25 percent of the unintended pregnancies recorded in the study.



UTILIZATION OF RESULTS

□ These findings have assisted CSI program managers to examine their clients' patterns of method use and their reasons for changing services. Program managers are considering relocating some clinics to make them more accessible to clients and are exploring the feasibility of using mobile clinics.

□ Based on the study recommendations, CSI obtained a grant to update its Management Information System (MIS). The MIS department is developing a database in Arabic that includes basic client data at the governorate level.

□ Mechanisms for follow-up were improved and outreach activities strengthened as a consequence of this study. CSI management is currently revising and updating the follow-up system and information, education and communication strategies.

□ A circular has been distributed to all CSI clinics that emphasizes counseling clients to return to the clinic if they are not satisfied with their contraceptive method, and stressing the risks involved in temporarily discontinuing the method. CSI physicians monitor this counseling during their visits to the clinics.

Makhoul, Hisham, and Saad Zaghloul Amin. 1995. Continuation and Discontinuation of Contraceptive Use by Method and Reasons for Drop-out in CSI Project. Cairo: Cairo Demographic Centre and the Population Council. May.

For further information on this study or to obtain a copy of the final report, please contact the Cairo Demographic Centre (CDC), 78 (4th St.) El Hadaba El Olya, Mokattam 11571, Cairo, Egypt. Tel: 20-2-347-0674, Fax: 20-2-346-8782. Or the Population Council, 6A Mohamed Bahie Eddine Barkat Street, 10th Floor, Giza, Egypt. Tel: 20-2-573--8277/570-1733, Fax: 20-2-570-1804.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.



COMMUNITY VOLUNTEERS SUCCESSFULLY REFER WOMEN TO REPRODUCTIVE HEALTH SERVICES

In Honduras, a simple reproductive health (RH) referral instrument developed for use by semi-literate community volunteers enabled them to make accurate referrals for needed preventive health and family planning services.

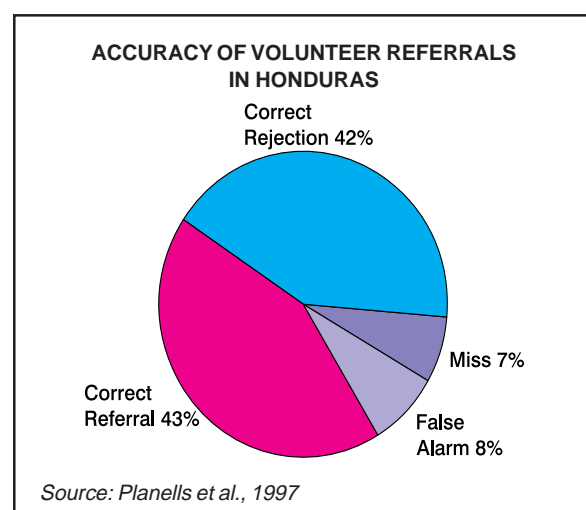
BACKGROUND

In Honduras, weak reproductive health service delivery is compounded by an ineffective referral system at the community level. Save the Children (STC) and the Population Council's INOPAL Project collaborated to design and evaluate a program to improve reproductive health referrals by semi-literate community volunteers. Project activities included assisting the Ministry of Health (MOH) in adding cytology and FP services to health care facilities; and adding pills and condoms to mini-pharmacies run by community volunteers. To strengthen the referral system, the project developed a job aid, or checklist, to facilitate reproductive health counseling and referral. The checklist is a simple matrix in which the "yes" or "no" responses of individual women to questions on health status and reproductive intentions are easily entered by the volunteers in columns and rows.

The project's evaluation methodology included monitoring the number of women contacted, the number of referrals made and kept, and the effectiveness of referral. Volunteers filled in the checklist for 12 simulated client contacts. The appropriateness of their responses were scored as a "hit," i.e. a preventive RH need existed and a correct referral was made; a "miss," i.e. an RH need existed but no referral was made; a "correct rejection," i.e. no service was needed and no referral made; and a "false alarm," i.e. no service was needed but a referral was made. Half of the simulated clients required referrals and half did not. If volunteer classification of clients were completely accurate, 50 percent of all clients would be referred and classified as "hits" and 50 percent would not be referred and classified as "correct rejections."

FINDINGS

□ Approximately 85 percent of all contacts resulted in appropriate referral behavior by the volunteer. Forty-three percent were "hits," or correct. Another 42 percent were correct rejections. The 15 percent incorrect response rate was almost equally divided between "false alarms" and "misses."



- Common reasons for false alarms included referring women for pap smears who did not require them, according to program norms, and advising women who were using temporary barrier methods such as condoms to go to the health center to switch to methods such as pills and IUDs which the volunteers felt were more effective. The largest number of misses occurred when women requiring tetanus vaccination were not referred to the health center.
- Volunteers contacted 1,184 women in 11 villages in five months. Approximately 60 percent of contacted women were referred for one or more reproductive health services. Even given the poor record keeping in health centers, it was obvious that large numbers of referred women visited the center as suggested by the volunteer.
- The findings demonstrate that adequately trained volunteers using a simple job aid can successfully detect and refer women in need of preventive reproductive health care services.

UTILIZATION OF RESULTS

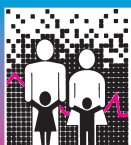
- Save The Children plans to extend the use of the instrument, and other non-governmental organizations have expressed interest in incorporating the job aid in their own volunteer programs.
- Information on the patterns of misses and false alarms are being used to strengthen the referral training curriculum.
- The Honduras Ministry of Health is adopting the job aid for use by auxiliary nurses in all rural health centers.

Planells, Marano, Luis Amendola, Irma Mendoza and Rebecka Lundgren. 1997. Systematic Provision of Reproductive Health Services by Community and Institutional Personnel. Tegucigalpa: Save the Children and the Population Council. July.

For more information or to receive a copy of the report, please contact Population Council, Residencial Casavola No. 37, Area Bancatlan, Miraflores, Tegucigalpa, Honduras, Tel/Fax: 504-32-60-21.

This project was supported by the Population Council's INOPAL III Project. INOPAL III is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-C-OO-95-00007-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

January 1998



IDENTIFYING CLIENT AND PROVIDER PERCEPTIONS ON QUALITY OF CARE

Clients and providers largely agree on what constitutes quality of care in services provided through family planning service delivery points (SDPs) in Kenya. Clients placed more emphasis than providers, however, on counseling for side effects, method choice, and FP education.

BACKGROUND

Little research has been carried out to determine how clients and service providers themselves define quality of care in family planning service delivery. This study, undertaken in 1994 by the Population Council's Africa OR/TA Project, explored the perceptions of both clients and providers on quality of care provided through public and NGO family planning SDPs in Kenya. Study methodology included focus group discussions, in-depth interviews with clients and service providers, and "simulated client" visits at nine SDPs in two rural and two urban locations. Four SDPs belonged to NGOs, and five were public clinics operated by the Ministry of Health (MOH) or the Nairobi City Council (NCC).

FINDINGS

□ Clients and providers agree that cost and proximity are two of the most important factors that attract or deter clients from using certain services.

□ A noticeable disparity exists between clients and providers on the issues of counseling for side effects and availability of method choice. While viewed by clients as major elements of service quality, neither are even mentioned by providers. Receiving counseling on only one method or a limited number of methods was a definite source of dissatisfaction for many women.

Client Comments on Quality of Care in Kenya

"The provider checks whether the coil is in position. Then urine is sent to the laboratory to exclude infections. I appreciate this service."

"I reported my problems to the provider and asked whether or not they could change the method. They said the method could not be changed to injection, but that the provider could insert the coil. She maintained that I must have a second child before she can give the injection."

"I asked them to give me the injectable. They told me that the pill was okay with me and I couldn't receive the injectable with only two children. I decided to stop and have never gone back."

Source: Ndhlovu, 1995

□ Both clients and providers identified medical examinations as a central factor affecting choice, continuation, and satisfaction with FP service delivery. Types of examinations clients felt were important were: weight taking, blood pressure checks, and cervical examinations.

- Providers and clients both give weight to provider attitude. Though few clients stated that they stopped using a clinic because of bad treatment, abuse of the provider discourages clients from continuing. Some clients reported having been rebuked if they used their method incorrectly, and lectured disapprovingly for making lifestyle choices of which providers personally disapproved.
- Both providers and clients recognized confidentiality and privacy as desirable characteristics of service delivery. Their definition of confidentiality differed, however: providers perceived it as frankness when examining and counseling, while clients defined it as keeping secret their contraceptive use.
- A surprising observation was that women did not view a clean health facility environment as a matter of concern.
- Long waiting time affected all clients surveyed. The ability of SDPs to deliver services promptly is often compromised by staff shortages and lack of space, but evidence suggests that providers could do much to minimize client waiting time.
- The personal biases of providers effectively deny young, unmarried men and women access to public FP services. NGO clinics were perceived as being more willing to provide them with services.
- Many clients felt that an important aspect of quality of care was the availability of maternal and child health and laboratory services, supporting a more integrated approach to providing reproductive health care. Providers also mentioned integration of services as important.

UTILIZATION OF RESULTS

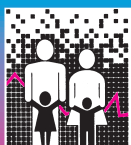
- Findings that brought out the age and marital restrictions imposed by providers on FP clients contributed to the MOH incorporating these issues into the Government's policy documents, including FP service delivery guidelines and the National Implementation Plan.

Ndhlovu, Lewis. 1995. Quality of Care in Family Planning Service Delivery in Kenya: Clients' and Providers' Perspectives, Final Report. Nairobi: Division of Family Health, Ministry of Health, and the Population Council. November.

For more information or to obtain a copy of the report, please contact Lewis Ndhlovu, Africa OR/TA Project II, Population Council, P.O. Box 17643, Nairobi, Kenya, Tel: (254)(2)713-480, Fax: (254)(2)713-479, E-mail: ORTA@popcouncil.or.ke.

This project was supported by the Population Council's Africa Operations Research and Technical Assistance Project II. The Africa OR/TA Project II is funded by the United States Agency of International Development (USAID), Office of Population, under Contract No. CCP-3030 C-00-3008-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

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QUALITY OF FAMILY PLANNING SERVICES SHOWS MARKED IMPROVEMENT

Kenyan program managers have improved family planning services provided through Ministry of Health (MOH) facilities, as demonstrated by comparing data collected under Situation Analysis studies in 1989 and 1995. Room for further improvement remains.

BACKGROUND

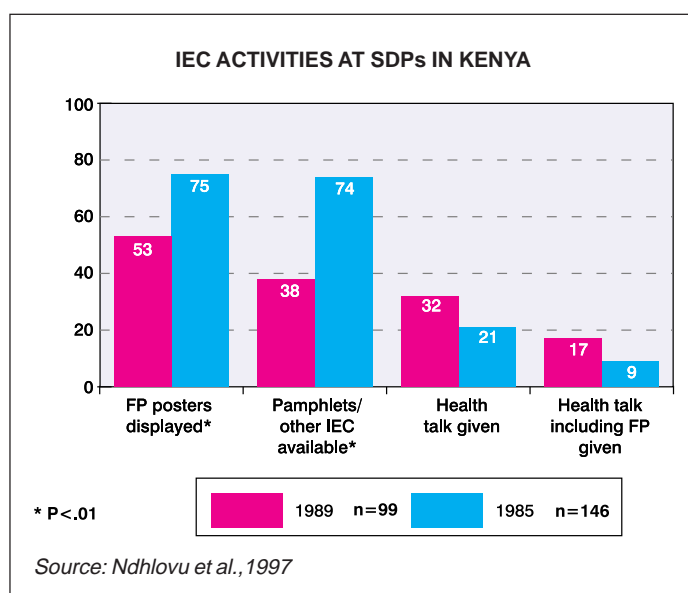
By 1993, 27 percent of currently married women in Kenya were using modern FP methods, an increase of 9 percent since 1989. The Ministry of Health's FP program is credited with having contributed to the increase. A Situation Analysis study of family planning services in Kenya carried out in 1989 by the Population Council provided data on specific areas where services provided through MOH service delivery points (SDPs) could be improved. The 1995 study sample was expanded from 99 Ministry of Health SDPs in 1989 to 147 MOH SDPs. The second study also gathered a broader range of information. Data were collected through interviews with 562 providers, observations of 958 FP clients, exit interviews with 927 FP clients (241 new clients, 717 revisit clients), and exit interviews with 1,738 maternal and child health (MCH) clients.

FINDINGS

□ The percent of MOH facilities displaying FP posters increased from 53 to 75 percent, and the availability of pamphlets and other IEC materials increased from 38 to 74 percent. Only 9 percent of facilities are currently using health talks to introduce FP, as compared to 17 percent in 1989.

□ On average, most new clients were told about six methods. Oral contraceptives are the method most frequently mentioned to new clients (86 percent), followed by injectables (83 percent), IUDs (74 percent), and condoms (72 percent). The percentage of clients hearing about foams/spermicides decreased.

□ Most facilities tend to have at least four methods available on site: oral contraceptives, condoms, injectables and the IUD. One-fourth of facilities now offer tubal ligation, and 11 percent offer vasectomy.



- Between 1989 and 1995, the availability of Depo-Provera at MOH facilities increased from 80 to 91 percent and NORPLANT® implants from 0 to 6 percent.
- One-third of MCH clients reported that they had seen or heard anything about family planning during the course of their visit. Sixty-six percent of them cited a poster as the source of FP information provided during visit.
- In 1995, more MOH clients heard about side effects and their management. The proportion hearing about how to use a method and its advantages stayed relatively constant.
- About two-thirds of MOH facilities are being supervised in accordance with MOH policy, i.e. once every three months. Two-thirds of supervisors asked about problems, and almost half observed several services during one visit.
- The percentage of MOH nurses receiving in-service training increased from about one-third to 60 percent.
- The proportion of MOH clients who were observed to hear about at least one other health issue during their FP consultation increased significantly, from 15 to 35 percent.

UTILIZATION OF RESULTS

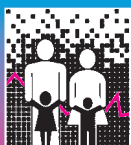
- The MOH, which is the main provider of FP services in Kenya, has used the 1995 Situation Analysis results in the preparation of two key documents: the MOH Reproductive Health Strategy and the National Implementation Plan for the Kenyan Family Planning Program for 1995-2000.
- The MOH is now implementing a follow-on study of the potential for greater provision of family planning information and services to MCH clients.

Ndhlovu, Lewis, Julie Solo, Robert Miller, Kate Miller, and Achola Ominde. 1997. An Assessment of Clinic-Based Family Planning Services in Kenya: Results from the 1995 Situation Analysis Study. Nairobi: Division of Family Health, Ministry of Health and the Population Council. January.

For more information or to obtain a copy of the final report, please contact the Africa OR/TA Project II, Population Council, P.O. Box 17643, Nairobi, Kenya. Tel: (254) (2) 713-480; Fax: (254) (2) 713-479; E-mail: ORTA@popcouncil.or.ke.

This project was supported by the Population Council's Africa Operations Research and Technical Assistance Project II. The Africa OR/TA Project II is funded by the U.S. Agency for International Development, Office of Population, under Contract No. CCP-3030-C-3008-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

January 1998



TRAINING PRIVATE MEDICAL PRACTITIONERS IMPROVES QUALITY OF CARE

Training private practitioners in family planning methods improved their technical knowledge and perception of family planning services and resulted in better quality of care for their clients. Physicians in private practice play an important part in the government strategy to increase access and improve the quality of family planning services in northern India.

BACKGROUND

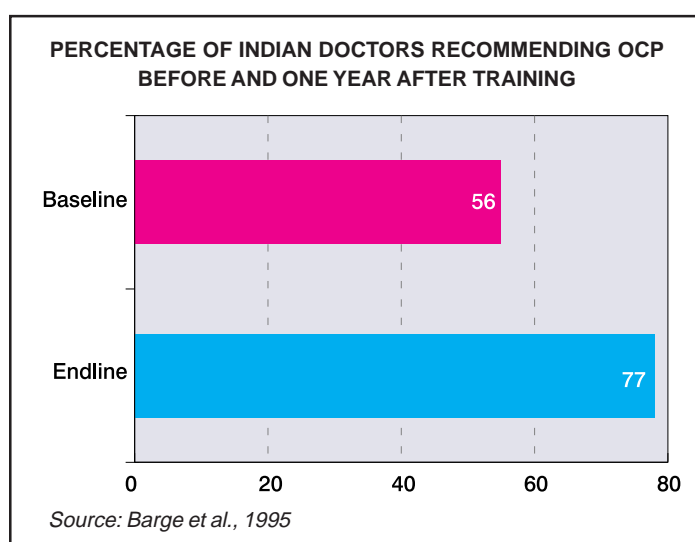
The Indian Medical Association (IMA), with training input from Development Associates and evaluation support from the Centre for Operations Research and Training (CORT), launched a project in 1992 to assess the feasibility of involving private medical practitioners in promoting family planning services, particularly the provision of oral contraceptive pills (OCP), among their clients. The goal was to improve physicians' perception of OCP through short training sessions and increase the percentage of women seeking family planning care from private practitioners. Approximately 1,300 private physicians were trained in two half day sessions held during a one week interval and a follow-up half day session one month later. This impact evaluation study used quantitative and qualitative approaches to document the experience and assess the management of the training sessions conducted by the IMA.

FINDINGS

□ An increase of 23 percentage points was reported in doctors recommending the oral contraceptive pill after they received training.

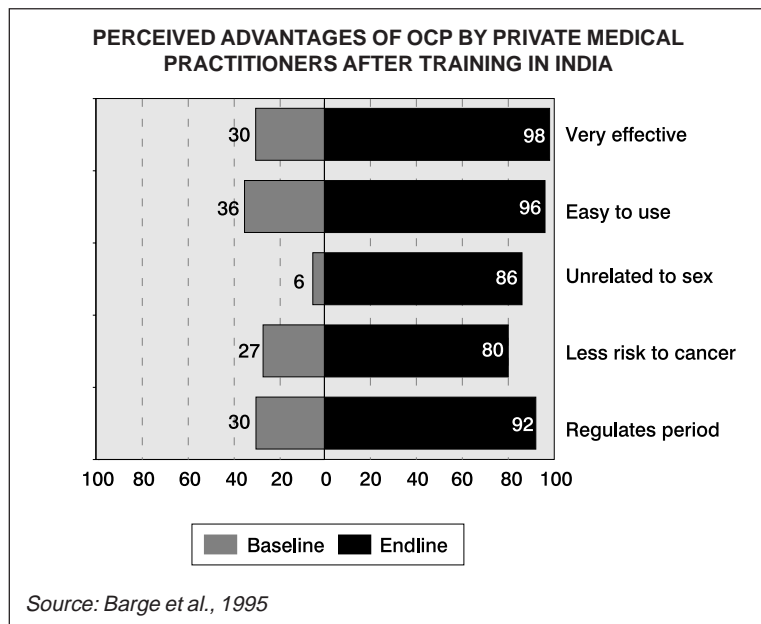
□ A mystery client study among a sample of doctors showed that trained doctors more often provided alternative choices of family planning methods than untrained doctors.

□ More clients were satisfied with the quality of service provided and the amount of time spent with them by the trained doctors. For example, a client who visited a trained doctor said, "I would recommend this doctor because he listened to me patiently and explained when the pills should be started, how it should be taken regularly..."



□ Despite the marginal increase in the number of clients actually accepting OCP after training, the physicians' improved competency and proficiency helped in enhancing the image of the program and improving the quality of care.

□ Significant increases were also achieved in the perception of OCP among trained physicians. For example, the percentage of doctors viewing OCP as 'very effective' increased by 68 percentage points, and 'easy to use' by 60 percentage points. They also viewed OCP more favorably than before in the categories 'unrelated to sex', 'decreases risk of pelvic infection and cancer' and 'helps in regulating periods'.



□ Although the physicians' technical knowledge about OCP increased significantly as a result of the training, many were still uncertain about critical information for clients, such as when to take the first pill in a packet and how to make the transition between packets. Some also retained misinformation about the potential risks of OCP use and stereotypes about the clients for whom OCP is an appropriate method.

□ Most doctors perceived the training to be both practical and of good quality. They were clearly interested in more information on family planning methods.

UTILIZATION OF RESULTS

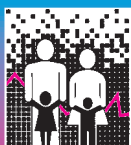
□ The Indian Medical Association training model has now been replicated and upscaled in the state of Uttar Pradesh, with modifications based on the results from this study. Modifications include expansion of training to include additional contraceptive methods, addressing the issue of counseling, doing more physician follow-up, introducing marketing and communications strategies to increase the draw of clients, and taking a more competency-based training approach.

□ The IMA training model needs further development, but, given the high demand for private medical services in Uttar Pradesh and throughout rural India, improving the competency of private physicians in family planning services is critically important.

Barge, Sandhya, Irfan Khan, Bella C. Patel and M. E. Khan. 1995. Use of Private Practitioners for Promoting Oral Contraceptive Pills in Gujarat. New Delhi: Centre for Operations Research and Training and the Population Council.

For further information on this study or to obtain a copy of the final report, please contact the Centre for Operations Research and Training (CORT), 402 Woodland Apartment, Race Course, Baroda 390 007, Gujarat, India. Tel: 91-265-326-453, Fax: 91-265-330-430. Or the Population Council, 53 Lodhi Estate, New Delhi 110003, India. Tel: 91-11-461-0913/461-0914, Fax: 91-11-461-0912.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.



FACTORS AFFECTING FAMILY PLANNING DROP-OUT RATES

Drop-out rates among family planning (FP) acceptors can be reduced by informing clients about possible side effects and the advantages and disadvantages of several methods. Local government support for the FP program and the attitude of husbands toward FP are also important factors.

BACKGROUND

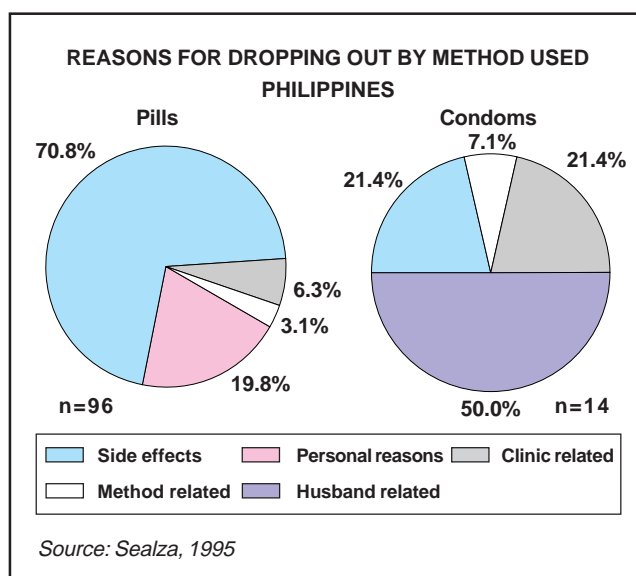
Government statistics indicate that by the early 1990s, around half of family planning acceptors throughout the Philippines were dropping out of the government FP program every year. Department of Health (DOH) data for Bukidnon province, for example, showed a 60 percent drop-out rate. This study examined the extent of the drop-out problem in Bukidnon, the reasons given by drop-outs for their decision to stop using FP, and the characteristics of drop-outs as compared to those who continued using FP. The study was carried out by the Research Institute for Mindanao Culture (RIMCU), Xavier University with technical assistance from the Population Council. The study team interviewed 400 married women who were family planning acceptors in 1992; held in-depth interviews with the FP Coordinator, nurses and midwives in the Barangay Health Stations (BHS); and observed provider-client interactions for one day each in a sample of 18 BHS.

FINDINGS

□ About 31 percent of FP acceptors drop out of the government program within a year of adopting a contraceptive method. All IUD acceptors (n=57) were still using some FP method at the time of follow-up. DOH clinic records on current users, drop-outs and switchers were accurate in 73 percent of all cases.

□ More than half of all drop-outs said they stopped using FP because of side effects. This response was particularly common among those using pills. The negative attitude of husbands towards condoms was a major factor why women stopped using this method.

□ Ninety-one percent of FP clients reported to be “satisfied” or “very satisfied” with their visits to the clinic. Clients who were dissatisfied cited unavailability of supplies and criticized the work of the local midwife.



- Most clients were not given a variety of methods to choose from. About 60 percent received information about only one method, and nine percent never received any counseling about FP. Even so, 98 percent of all respondents said they were given the freedom to adopt whatever FP method they desired.
- FP trainers were given high ratings with regards to friendliness and their ability to “clearly explain” how to use the method and its advantages. The trainers seemed less capable, however, when it came to explaining the method’s disadvantages and side effects. This response was particularly common among those who were using contraceptive pills.
- Women with less education, lower socio-economic status, no paid employment during the past year, a greater number of pregnancies, and a less favorable attitude towards FP were most likely to become drop-outs. Lack of support for FP on the part of the husband was found to be a more important factor in dropping out than the attitude of the acceptor herself.
- Drop-out was highest among condom acceptors, followed by pill and IUD acceptors respectively. Clients who had to return to the clinic each month for a resupply of contraceptives were more likely to drop out.
- Better quality of care was generally associated with lower levels of dropping out. Clients who received information on more than one method and some orientation on possible side effects were less likely to drop out.
- The situation analysis pinpointed several problem areas, including: personnel without training in IUD insertion; inadequate infrastructure, particularly lack of running water; and irregular visits by supervisors. Cleanliness and storage facilities were generally adequate.

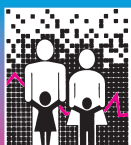
UTILIZATION OF RESULTS

- FP service providers now utilize FP clinical standards and the manual as a guide for running day-to-day operations in the clinic.
- During training and supervision, emphasis is now put on the importance of informing clients about possible side effects and complications, and the advantages and disadvantages of specific methods.
- The local government units (LGUs) conducted program reviews, which have led to submission of budget proposals for improving the stock of basic supplies at rural health units and increased support by some LGUs for the FP program.
- More efforts are being made by the public program to inform men of the advantages of family planning.

Sealza, Lita. 1995. Factors Affecting the Family Planning Program Drop-Out Rate in Bukidnon, Philippines. Manila: Research Institute for Mindanao Culture, Xavier University and the Population Council.

For further information on this study or to obtain a copy of the final report, please contact the Population Council, Monteverde Mansions #17, 85 Xavier Street, Green Hills, San Juan, Metro Manila, Philippines. Tel: 63-2-722-6886, Fax: 63-2-721-2786.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.



INCREASING THE USE OF REPRODUCTIVE HEALTH SERVICES

A series of questions used by providers to screen clients at service delivery points (SDPs) was effective in increasing awareness and use of family planning, pap tests, and screening for sexually transmitted infections (STIs), but less effective in increasing use of other SDP services.

BACKGROUND

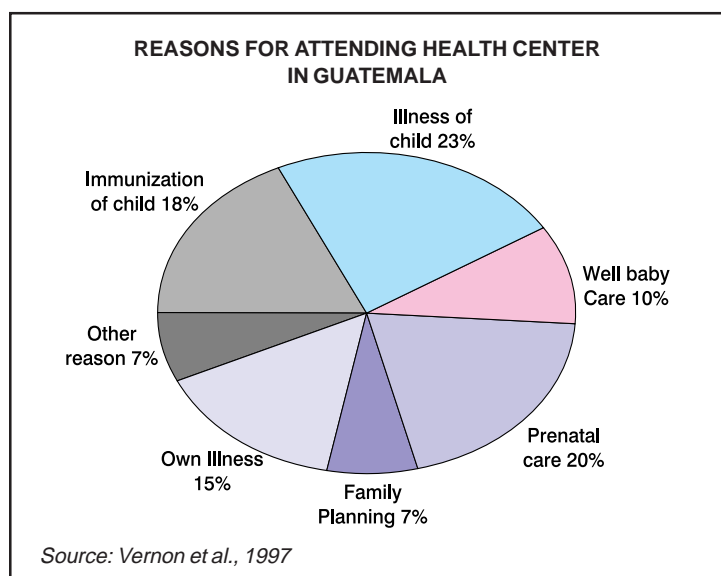
Most health systems do not screen patients for an unmet need for family planning or other reproductive health services. In Guatemala, the Ministry of Health (MOH) and, in Mexico, the Social Security and Services for State Workers (ISSSTE), with assistance from the Population Council's INOPAL OR/TA Project, tested a job aid to help providers detect unmet need for services, provide comprehensive RH care, and increase the number of users of different services. The job aid, an algorithm of seven questions, each answered by a simple yes or no, helps providers segment clients into different categories of unmet need for services, such as prenatal care or family planning. In Guatemala, the MOH trained service providers of 55 health centers and posts in the use of the algorithm, and compared them to 31 health outlets where no training was done. In Mexico, the staff of one large SDP was trained in the use of the algorithm. Researchers conducted exit interviews with clients at both sites to assess the degree to which services had been offered. In addition, service statistics were collected to observe project impact on service use.

FINDINGS

Guatemala

□ The main reasons why women visited the SDP were illness of a child (23 percent), prenatal care (20 percent), immunization of children (18 percent), personal illness (15 percent), well baby care (10 percent), and family planning (8 percent).

□ The job aid appears to have been perceived by providers primarily as a tool to promote family planning. SDPs that used the algorithm showed a greater than expected productivity in FP services but not in other reproductive health services such as prenatal care and postnatal care.



□ Service providers who had been trained in the use of the job aid provided information on family planning methods to 36 percent of their clients, compared to 26 percent of women where the staff had not been trained.

□ In the last nine months of 1996, SDPs that used the job aid had 124 percent more new family planning clients than in 1995. SDPs in the control group saw an increase of 21 percent.

Mexico

□ In Mexico, before introduction of the job aid, no RH services were offered to more than five percent of clients, with the exception of the pap test, which was offered to 32 percent of all women of reproductive age. After training, 21 percent of women were offered screening for sexually transmitted infections; 35 percent were offered FP services; and 66 percent were offered a pap test. On average, training in the use of the job aid helped increase the number of services provided by 10 percent, compared to the four month period before the training.

UTILIZATION OF RESULTS

□ In Guatemala, the MOH will conduct a larger scale test of the job aid facilities.

□ In Mexico, the Mexican Social Security Institute for Government Workers (ISSSTE) has used this study to further institutionalize the development and implementation of operations research projects in-house.

Vernon, Ricardo, Emma Ottolenghi, Jorge Solórzano, Luis Roberto Santamarina, Juan José Arroyo, and Clara Luz Barrios. 1997. Systematic Offering of Family Planning and Reproductive Health Services in Guatemala. Guatemala City: Ministry of Health of Guatemala and the Population Council. April.

Dominguez del Olmo, Javier, Marco Antonio Olaya, Francisco Javier Gomez Glavenlina and Ricardo Vernon. 1997. Using Operations Research to Solve Reproductive Health Problems. Mexico City: Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado (ISSSTE), National Autonomous University of Mexico (UNAM), and the Population Council. June.

For more information or to receive a copy of this report, please contact Ricardo Vernon, Deputy Director, INOPAL III, Population Council. Escondida 110, Col. Villa Coyoacan, 04000, Mexico, D.F., Mexico, Tel:52-5-659-8541, Fax: 52-5-554-1226, E-mail: rvernon@laneta.apc.org.

This project was supported by the Population Council's INOPAL III Project. INOPAL III is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-C-OO-95-00007-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

MAXIMIZING ACCESS AND QUALITY OF CARE (MAQ)

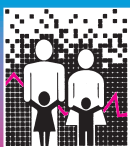
SITUATION ANALYSIS



Sean Sprague (Unicef)

The **Situation Analysis** methodology developed under the operations research projects is now the accepted standard in helping program managers and policy makers identify gaps in their programs and develop appropriate interventions. **Situation Analysis** studies have also been useful in establishing baseline data against which to measure improvements in services.

Operations research to improve access and quality of services has included **Situation Analysis** studies of public and private sector reproductive health services. Utilization of **Situation Analysis** data is an increasingly common element of local planning of health services.



SITUATION ANALYSIS OF FAMILY WELFARE CENTERS

The study identified areas in which the Family Welfare program needs improvement, including staff training, information materials, client counseling, inventory and supply of contraceptives, and community outreach. A pilot project for rural areas is addressing many of these issues.

BACKGROUND

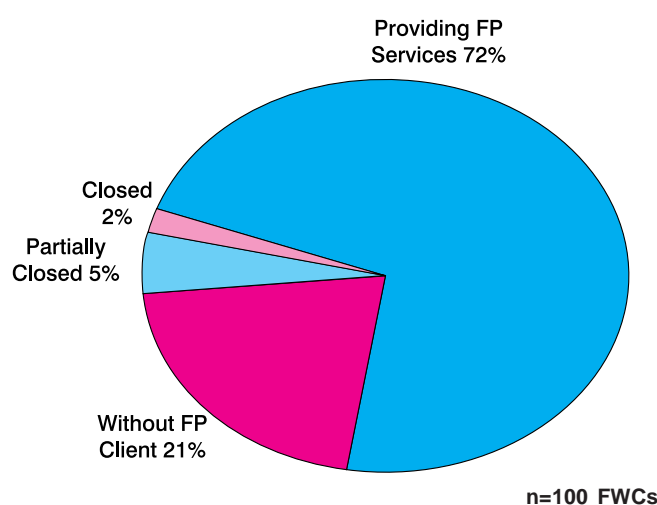
Although the current use of family planning (FP) methods in Pakistan has increased from 12 to 18 percent since 1990, a significant number of couples still wish to limit their family size, which suggests that the FP service delivery system needs improvement. Family Welfare Centers (FWCs) are the government's main FP service delivery outlets and serve the majority of current contraceptive users. Services offered through FWCs include FP counseling and services, maternal and child health care, health education, and training of community volunteers. At the request of the Ministry of Population Welfare, the Population Council carried out a Situation Analysis of FWCs in 1992, with the objective of providing an overview of the availability, functioning and quality of their FP services. Research teams checked contraceptive supplies and equipment, inspected facilities, observed counseling sessions and interviewed staff and clients at 100 of the country's 1,288 FWCs.

FINDINGS

□ Of the 100 FWCs included in the study, 72 provided services to FP clients on the day of the team's visit. Seven FWCs were closed, had no service providers present or had the contraceptives locked up. Twenty-one had no clients on the day the team visited, but staff were present.

□ An average of 2.8 FP clients came in on the day of the visit. Clinic records for May 1992 indicated an average of 4.6 FP clients per day. Eighty percent of clinics serve an average of fewer than 150 FP clients per month. In FWCs, the IUD is the most frequently accepted method, followed closely by oral contraceptive pills, injectables and condoms.

STATUS OF FAMILY PLANNING SERVICES PROVISION ON THE DAY
OF VISIT AT FAMILY WELFARE CENTERS, PAKISTAN



Source: Cernada et al., 1993

□ Approximately 20 percent of FWCs did not have the following: an examination table, equipment for sterilizing instruments, blood pressure cuffs, or syringes. Forty percent had no antiseptic lotion.

□ Most FWCs can be reached by public transport and over 90 percent by road. Three-fourths of clients came on foot, however, and one-half travelled less than 15 minutes.

□ Female professional staff were present at 83 FWCs on the day of the visit. Staffing records indicate that 95 percent of the centers open the day of the visit have Family Welfare Workers, and over 80 percent have both male and female Family Welfare Assistants.

□ Of the 84 FWCs where information on contraceptive supplies was available, 23 percent lacked some supplies. All had condoms; 77 percent had Copper T380s; 87 percent Lippes Loops; 83 percent had injectables; and 89 percent had pills.

□ Signboards identified 85 percent of FWCs. Forty-one percent had informational pamphlets on FP methods. No clients were given pamphlets to carry away; pamphlet language was inappropriate in 30 percent of FWCs.

□ Nearly all staff said that community outreach was part of their job, but during the month prior to the study, 65 percent conducted no home visits, 70 percent no community meetings, and 96 percent no meetings in schools or factories.

□ In counseling sessions with potential acceptors, staff mentioned condoms in one-third of the sessions, pills and IUDs in two-thirds, and tubectomy in two-fifths. Many did not discuss how a method works, how to use it, or its effectiveness. Contraindications were infrequently mentioned.

□ Staff took a medical history of 68 percent of new clients. Ninety percent of staff said that high blood pressure was a contraindication to pills and injectables, but checked the blood pressure of only 20 percent of clients.

UTILIZATION OF RESULTS

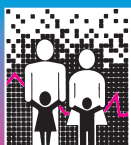
□ Using the data from the Situation Analysis, a pilot program to provide 12,000 village-based family planning workers was initiated as part of the government's eighth five year plan (1993-98). The new program's goal is more FP outreach, particularly in rural areas.

Cernada, George P., Ubaidur Rob, Saifia I. Ameen, Muhammad Shafiq Ahmad. 1993. A Situation Analysis of Family Welfare Centers in Pakistan. Islamabad: The Ministry of Population Welfare and the Population Council.

For more information on this study or to obtain a copy of the final report, please contact the Population Council, House No. 55, Street No. 1, Sector F 6/3, Islamabad, Pakistan. Tel: 9251-277439, 827536, Fax: 9251-821401.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

January 1998



SITUATION ANALYSIS OF FAMILY PLANNING SERVICES IDENTIFIES PROGRAM GAPS

This Situation Analysis (SA) study of clinic-based family planning services in Senegal identified program gaps in training, supervision, and equipment which national and regional FP staff have used to develop program strategies, establish quality of care indicators, and develop regional workplans.

BACKGROUND

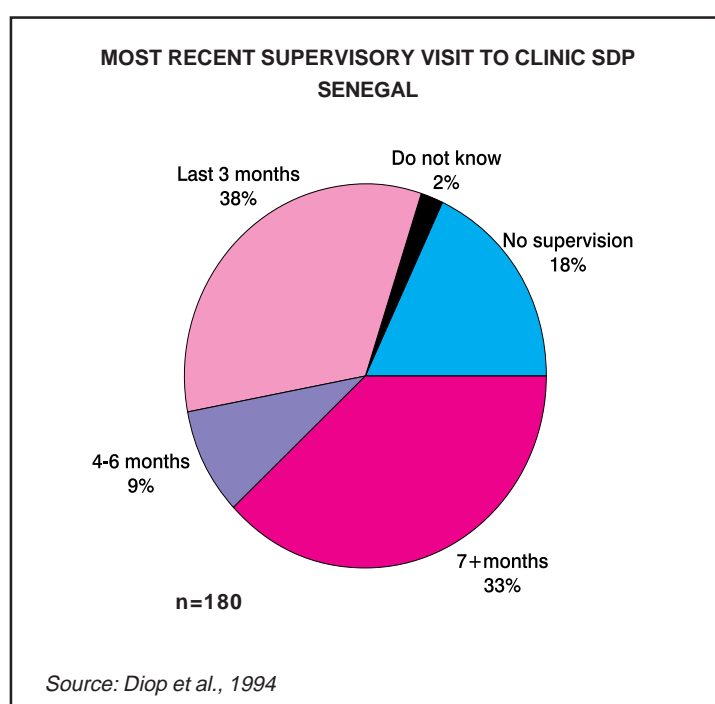
Senegal's National Family Planning Program (PNPF) coordinates nationwide family planning activities, promotes the integration of family planning with maternal and child health (FP/MCH) services, and serves as a central channel for funding and program direction. In 1994 PNPF carried out this SA study of clinic-based FP services with technical assistance from the Population Council's Africa OR/TA Project. The study provides descriptive information on the availability, functioning and quality of FP services provided through the country's 180 service delivery points (SDPs); identifies program strengths and weaknesses; formulates recommendations for the USAID-funded Program on Child Survival and Family Planning; and provides quality of care indicators for the Ministry of Health and Social Action. Researchers inventoried supplies, equipment, and facilities; observed provider-client interactions; and interviewed FP and MCH clients and FP staff.

FINDINGS

□ Fifty-three percent of FP clients and 35 percent of MCH clients have at least four children. More than one-fourth of FP clients and almost one-fifth of MCH clients do not want any more children.

Approximately one-third of the women were breastfeeding at the time of the survey.

□ Only 38 percent of SDPs had been visited by a supervisor during the three months prior to the survey; one-third had not received a supervisory visit in seven months or more, and 18 percent had received no supervisory visits at all.



- Most SDPs offered a variety of contraceptive methods. More than 80 percent of new clients obtained their preferred contraceptive method. In most cases, other possible methods were not discussed. More than 95 percent of clients received a written reminder of when to return for method resupply.
- Fifty-two percent of SDPs had a record system in place for tracking contraceptive supplies and ordering. Pills, condoms and spermicides are available at all SDPs. The IUD and injectables are available at 78 percent and 63 percent of SDPs, respectively. Over 20 percent of SDPs had stockouts of injectables.
- Sixty-two percent of service providers say they have received training in clinical FP; 26 percent have received training in counseling; 24 percent in IEC; and 13 percent in HIV/AIDS counseling. The majority of family planning providers are midwives whose formal training has been limited to the management of pills and IUDs.
- Client counseling on method side effects and how to manage them was inadequate. Provider-imposed non-medical barriers to the provision of contraceptive methods existed in terms of age, parity, and marital status. Providers asked only 56 percent of new clients about their reproductive intentions.
- Eighty percent of SDPs had FP and MCH posters, but only 40 percent had a visible sign announcing the availability of FP services.
- At virtually all SDPs, FP services are offered within the context of a wide range of services. However, FP was discussed in only 36 percent of MCH interactions.
- Concerns about HIV/AIDS were discussed in only 1 percent of new client visits, and STI history was discussed in only 3 percent.

UTILIZATION OF RESULTS

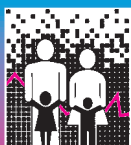
- PNPF and key donor agencies, notably USAID, have used the SA data to develop a set of indicators describing the quality of care provided by the program. These indicators are being used to evaluate progress in strengthening the program.
- Dissemination of study results culminated in development of workplans by regional FP staff. Many providers felt empowered to establish new procedures and propose changes that could be managed at the local level and implemented immediately.

Diop, Marième, Isseu Touré, Nafissatou Diop, et al. Analyse Situationnelle du système de prestation de services de planification familiale au Sénégal. 1995. Dakar: National Family Planning Program, Ministry of Health and Social Action and the Population Council. October.

For more information or to receive a copy of this report, please contact Diouratié Sanogo, Deputy Director, Africa OR/TA Project II, Population Council, Villa Nx4, Stele Mermoz, Route de Pyrotechnie, B.P. 21027, Dakar, Senegal, Tel: (221) 24-19-93, Fax: (221) 24-19-98, E-mail: pcdakar@sonatel.senet.net.

This project was supported by the Population Council's Africa Operations Research and Technical Assistance Project II. The Africa OR/TA Project II is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-3030-C-00-3008-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

January 1998



SITUATION ANALYSIS OF REPRODUCTIVE HEALTH CARE SERVICES

Although linkages between family planning, postpartum and abortion services exist, not all of the patients for those services were able to obtain a contraceptive method at the time of their consultation.

BACKGROUND

The family planning program in Turkey has been providing permanent contraceptive methods (female tubal ligation and more recently vasectomy) for a number of years. These services are provided in tertiary care centers in seven regions. A Situation Analysis study of several reproductive health care services was conducted through a cooperative effort between the Ministry of Health and Gazi University, with technical assistance provided by AVSC International and the Population Council. The aim of the study was to describe the availability, functioning and quality of family planning (FP) and abortion services, and to analyze the linkages between family planning and antenatal, postpartum and abortion services. The study was conducted in 47 facilities, including both hospitals and MCH/FP centers.

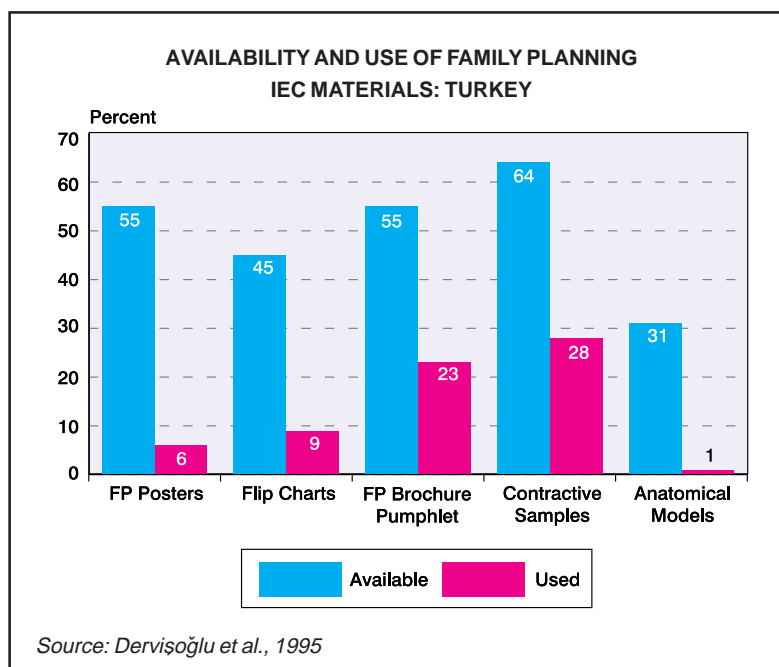
FINDINGS

Counseling and information exchange

□ IEC materials (FP posters, flip charts or brochures) were present in half of the family planning clinics but they were seldom used. Only one-fifth of the staff, including providers of sterilization services, have received IEC training.

□ Only 30 percent of family planning clients received counseling in a private area. Complete information on contraceptive methods was not adequately discussed during counseling.

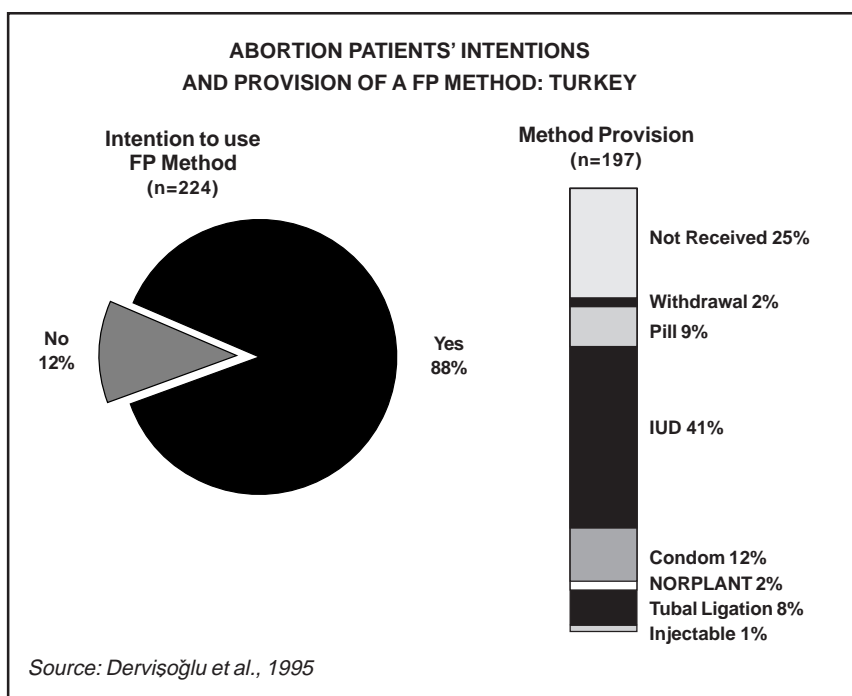
□ Only half of all clients receiving a pelvic examination received an explanation of the procedure, and more than one-third were not informed of the findings.



Method choice

Of the clients interviewed, two-thirds decided during their pregnancy to use a FP method postpartum, one-fifth decided following delivery, and the rest could not decide. Only one-tenth of postpartum patients received the method before leaving the hospital.

The majority of abortion patients decided to use a contraceptive method. Two-thirds received the method before leaving the hospital.



Technical competence

Only one-tenth of the staff in all services knew that the combined pill could be given two weeks after delivery if the woman is not breastfeeding, and six months after delivery if she is breastfeeding. While only one-half of family planning outpatient staff could report that an IUD can be inserted at any time if the woman is not pregnant, only one-sixth of the clinic staff indicated that an IUD could be inserted immediately or within 48 hours of delivery.

Sterile or clean gloves were used during all FP procedures, although in most cases the providers did not wash their hands. Providers used clean gloves in 30 percent of the abortion procedures, but no gloves in 16 percent of them. Before most abortion procedures, the instruments were not sterilized and the providers did not wash their hands.

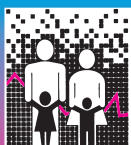
UTILIZATION OF RESULTS

The Turkey Situation Analysis study was used to assist in formulating strategies for IEC activities in the National IEC Training Strategy. The findings were also used to establish the rationale for introduction of National FP Clinical Guidelines during a Social Security Administration workshop, and have been a principal data source for the development of the government's MCH/FP National Strategic Plan.

Dervişoğlu, Ayşe Akin, Mehmet Ali Biliker, Mehmet Ali Bumin, Cigdem Bumin, Dale Huntington, Barbara Mensch, John Pile, Derman Boztok. 1995. Turkey Situation Analysis Study of Selected Reproductive Health Care Services, Final Report, Condensed English Version. Cairo: Ministry of Health (Turkey), the Population Council and AVSE International (Turkey). June.

For further information on this study or to obtain a copy of the final report, please contact AVSC/Turkey Country Office, Abidin Daver Sokak 7/6-7, Cankaya 06550, Ankara, Turkey. Or the Population Council, 6A Mohamed Bahie Eddine Barakat Street, 10th Floor, Giza, Egypt. Tel: 20-2-573-8277/570-1733, Fax: 20-2-570-1804.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.



SITUATION ANALYSIS DATA EVOKES IMMEDIATE RESPONSE

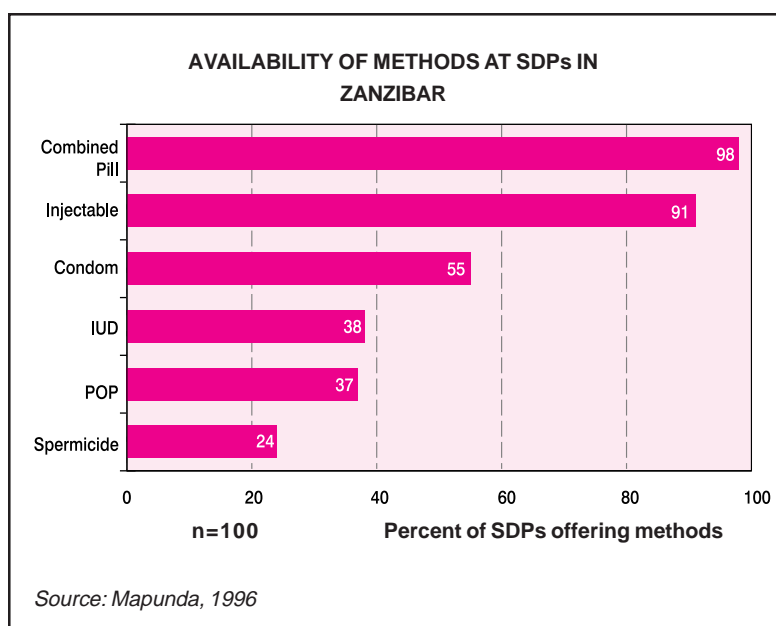
A Situation Analysis (SA) study of family planning services identified gaps in equipment and supervision that the MCH/FP unit of the Government of Zanzibar began working immediately to fill. The government is also using the results to plan the next phase of the national program, which will integrate reproductive health, family planning and safe motherhood services.

BACKGROUND

From the start of its Zanzibar Family Planning Project (ZFPP) in 1985, the Government of Zanzibar conceived family planning (FP) services as an integral part of the overall maternal and child health (MCH) care services. From six clinics in 1985, the program expanded to 104 in 1995. However, the Government of Zanzibar remains concerned that services are underutilized, with contraceptive prevalence of modern methods estimated at 6.6 percent by the Tanzania DHS of 1992. In response to this concern, a SA study was conducted by the Government with technical assistance from the Population Council's Africa OR/TA Project. The SA objective was to provide comprehensive information on the availability, functioning, and quality of FP services in order to plan for the needed improvements and expansion of the program. The study covered 100 out of the 104 family planning service delivery points (SDPs) on the islands of Unguja and Pemba.

FINDINGS

□ FP clients are highly concentrated in a few SDPs: one SDP alone handles one-third of the roughly 75,000 annual family planning visits, and a second SDP receives another fifth of all visits. The remaining SDPs average 57 new acceptors and 340 revisits per year. Family planning visits account for 12 percent of all MCH visits.



- Almost all SDPs offer combined oral contraceptives and injectables, but only 55 percent offer condoms, and fewer than half offer progestin-only pills (POP), IUDs, or spermicides.
- During consultation, pills and injectables were by far the most commonly mentioned methods; IUDs and condoms were mentioned in about two-thirds of observed interactions and other methods in fewer than half.
- Over 80 percent of the clinics have clean examination rooms with adequate privacy and light. Virtually all have access to sterilizing equipment, specula, blood pressure machines, and stethoscopes. However, more than half have no running water, two-thirds have no electricity, 60 percent lack thermometers, and almost half are missing a flashlight or angle poise lamp, gloves, needles, and syringes.
- The majority of family planning providers in Zanzibar are MCH Aides. Two-thirds of those interviewed had been trained or retrained in FP within the last five years and more than 80 percent had received a supervisory visit in the previous three months.
- Only 36 percent of new users were asked about their spacing or limiting needs; one-half were asked about their breastfeeding status.
- Four out of five new users were told how to use a method, but far fewer were given additional information about advantages, disadvantages, side effects, and what to do if problems arise.
- Almost one-fourth of providers will not provide a contraceptive method to an unmarried woman. Between 32 and 56 percent of providers, depending on the method, require spousal consent for a prescription; and half or more place parity restrictions on all methods, particularly injectables.
- Four-fifths of all new clients were weighed, had their blood pressure taken, and were asked their medical history and date of last menstrual period. However, half or fewer had a breast or pelvic examination or were asked about unusual bleeding, pelvic pain, or discharge.

UTILIZATION OF RESULTS

- Senior MOH officials, MCH/FP coordinators, senior program staff, UNFPA, WHO, UNICEF, and members of the Family Planning Advisory Committee are using the SA results to plan the next five-year phase of the ZFPF, which will be a broader-based reproductive health, family planning, and safe motherhood program.
- The MCH/FP unit has purchased and distributed equipment found missing during the study. IEC activities have been intensified and planning for refresher and newcomer courses is underway. Management and supervisory courses for the MCH/FP supervisors have also been incorporated into the next phase of the program.

Mapunda, Patiens and the Africa OR/TA Project II. 1996. The Zanzibar Family Planning Situation Analysis Study. Nairobi: Ministry of Health, Tanzania and the Population Council. May.

For more information or to obtain a copy of the report, please contact the Africa OR/TA Project II, Population Council, P.O. Box 17643, Nairobi, Kenya, Tel: (254)(2)713-480, Fax: (254)(2)713-479, E-mail: ORTA@popcouncil.or.ke.

This project was supported by the Population Council's Africa Operations Research and Technical Assistance Project II. The Africa OR/TA Project II is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-3030 C-00-3008-00, Project No 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

January 1998

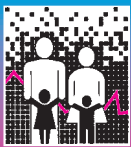
CONTRACEPTIVE OPTIONS



Shari Kessler (ANE OR/TA Project)

The ability to choose from a range of **contraceptive options**, both modern and traditional, is a fundamental element of quality and a right of all users of family planning services. No single method is adequate for every person's needs. Some methods provide protection against STIs as well as protection against pregnancy. Age, gender, and lifestyle all influence users' choices. Providing a range of **options** ensures that a client's concerns about the safety, effectiveness, cost, and convenience are addressed. Expanding **contraceptive options** studies have made major contributions to national policies and programs.

Operations research on **contraceptive options** has focused on the use dynamics of specific methods and client preferences, efforts to improve client information and counseling, and strategies to provide emergency contraception in case of unprotected intercourse or contraceptive failure.



SATISFACTION WITH DIAPHRAGM HIGH AMONG POOR WOMEN IN MADRAS CITY

Poor women in the city of Madras, India chose the diaphragm and were satisfied when it was added to the range of contraceptives offered as part of a comprehensive community outreach program on reproductive health.

BACKGROUND

This feasibility study examined user perspectives regarding the desirability of the diaphragm as a contraceptive method when included among other methods distributed without cost through family planning clinics serving lower income, urban neighborhoods in Madras, India. The project was carried out by the Rural Women's Social Education Centre, Tamil Nadu with assistance from the Population Council's ANE OR/TA Project. Information dissemination on contraceptive options was part of a comprehensive community outreach program on reproductive health education in the catchment areas of three service delivery points, two implemented by a non-governmental organization and one by a women doctor's association. The project's emphasis was on adding the diaphragm to the present range of contraceptives. The study documented the profile of 97 diaphragm acceptors and their experiences with the method over the first month of use.

FINDINGS

□ At the time of the baseline survey, 2,295 non-pregnant women of reproductive age were living in the study area, with a CPR of 66 percent. Fifty-three percent of the women were sterilized, 13 percent were using a temporary contraceptive method, and the rest were not using any method. Following the supply of diaphragms, diaphragm acceptors represented about 8 percent of potential users and four percent of all non-pregnant women of reproductive age in the study area.

Profile of Diaphragm Acceptors

- Women who are breastfeeding
- Women want to space a second birth
- Women who have small children and prefer to wait before adopting a permanent method
- Women whose husbands are working elsewhere
- Women who have sex infrequently, but are at risk of an unwanted pregnancy

Source: Sundari, 1995

□ No woman was fitted with a diaphragm bigger than 65mm. All preferred to use it with spermicide. Virtually all women said they used the diaphragm for every sexual contact.

□ Irrespective of their education level, all acceptors reported that they thought the method was appropriate and easy to use. Only one person had difficulty with insertion after returning home and had to be retrained.

- Absence of a bathroom or toilet at home did not pose a problem. Storage and maintenance of the diaphragm was not problematic.
- The majority of acceptors were young women with one or two children, and most had never used a contraceptive method before. None of the women with four or more living children chose to use the diaphragm.
- Practically all women over 40 included in the study are sterilized. Twenty-six women switched from pills, condoms or the IUD to the diaphragm, either to avoid side effects or to have more control over method use.
- Twice as many married women in the 15 to 19 age group are diaphragm users (14 percent) when compared to other age groups (7 percent). The data suggest that the diaphragm has an important role in delaying births, particularly the second birth, among younger women who are underserved by the methods currently available.
- The key advantages of the method, from the users' perspective, were the absence of side effects and the possibility of using it only when needed and not on a continuous or daily basis.
- The investment of time and effort in community outreach and education, and the high quality of the service delivery were important factors in acceptance and use of the method. Acceptors mentioned the kindness shown by the doctors, their willingness to explain diaphragm use in detail, and their patience in insertion training as important motivating factors.

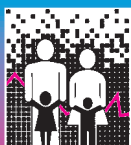
UTILIZATION OF RESULTS

- Several NGOs are exploring the feasibility of including the diaphragm in their reproductive health programs. The study suggests that inclusion of the diaphragm among the methods offered by FP programs in India would meet the needs of a significant portion of women who are looking for a safe, user-controlled method.
- The Indian Council of Medical Research is testing the acceptability of the diaphragm in its Human Reproduction Research Centers, when offered along with a wide range of other contraceptives.
- Additional research is planned on the acceptability and use dynamics of the diaphragm and other barrier methods in reproductive health programs with a user perspective.

Sundari, T.K. 1995. A Study of User Perspectives on the Diaphragm in an Urban Indian Setting. New Delhi: Rural Women's Social Education Centre (Madras) and the Population Council. June.

For further information on this study or to obtain a copy of the final report, please contact the Rural Women's Social Education Centre, Chengalpattu, Tamil Nadu. Or the Population Council, 53 Lodhi Estate, New Delhi 110003, India. Tel: 91-11-461-0913/0914, Fax: 91-11-461-0912.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.



CREATING CONDITIONS FOR A SUSTAINABLE FAMILY PLANNING PROGRAM

Data from this study indicate that most women in Indonesia are obtaining removal of NORPLANT® on time and are willing to pay for removal services. However, they need to know ahead of time what the cost will be for contraceptive services, so they can make an informed choice that fits their financial circumstances.

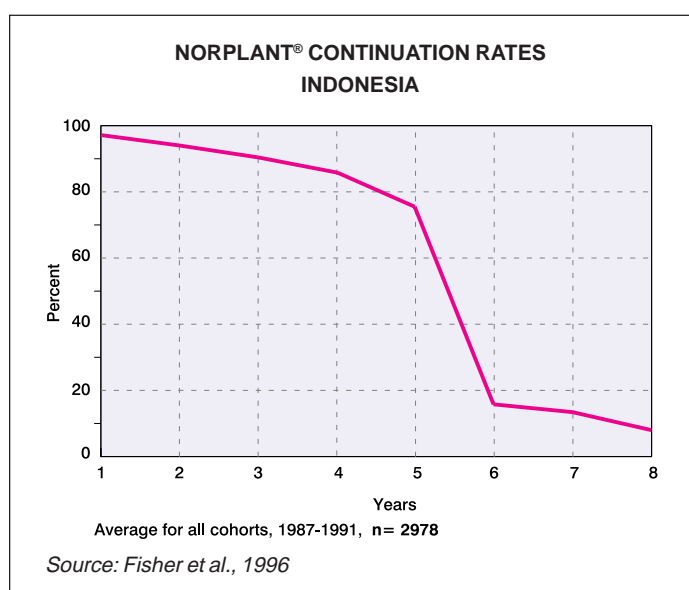
BACKGROUND

As of March 1995, National Family Planning Coordinating Board (BKKBN) service statistics indicate that the cumulative number of NORPLANT® acceptors in Indonesia exceeded 2.6 million. BKKBN has developed a client tracking plan and has initiated an accelerated program to increase the availability of removal services. In order to obtain information on the extent to which removal of implants was being completed on time, BKKBN, in collaboration with the Department of Community Medicine (Medical School, University of Indonesia) and the Population Council, conducted a study of a representative sample of women who accepted NORPLANT® between April 1987 and March 1991. Twenty teams of researchers interviewed 2,979 women in 14 provinces, obtaining data on continuation rates; facilities and providers used for insertion and removals; complications or side effects experienced; barriers to removal; the role of the private sector in removals; and the experience of NORPLANT® clients during the past five-year period.

FINDINGS

□ At the time of their NORPLANT® acceptance, the mean age of the women was 28 years. They had an average of three living children, half of them had little or no education, half of their husbands worked in agriculture or fishing, 90 percent lived in rural areas, and 70 percent worked at home.

□ Ninety percent of acceptors are still using NORPLANT® four years after insertion. Approximately two-thirds continue to use NORPLANT® for five years, and 90 percent obtain removal before six years. Thus, only 8 percent have not yet had NORPLANT® removed. The data strongly suggest that removals are under-reported and that there is not a large backlog of removal cases, particularly after the sixth year of use.



- Only 16 percent of those who are overdue for a removal use any other form of back-up contraception.
- About five percent, or 89 women, have used NORPLANT® for at least 7 years. Of those, 67, or 4 percent, are married, younger than 45, and presumably sexually active.
- Continuing users tend to be older, divorced or widowed, have more living children, accepted NORPLANT® to stop (rather than postpone) the next pregnancy, and were less likely to be informed about the need for a removal after five years of NORPLANT® use.
- Two-thirds of removals are performed by nurse midwives. About 28 percent are performed in private facilities; 23 percent are done in mass camps.
- About 91 percent of all women who have had a removal received the removal immediately upon request. The remaining 9 percent often had to wait several days and make two or more requests before obtaining a removal.
- Almost 70 percent of all women said they had not been informed at the time of NORPLANT® insertion that a fee would be charged for removal. Three-fourths of women who had a removal were charged a removal fee. The majority of them considered the removal fee “average” and 15 percent considered the fee “expensive”.
- Over one-fourth of those who had not yet had a removal cited cost as the major reason; 12 percent were afraid of the removal process, and 9 percent forgot the date.

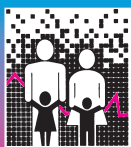
UTILIZATION OF RESULTS

- The study was presented at the BKKBN's mid-year pre-programme review in October 1996 and served as the main planning materials for officials from 27 provinces at the BKKBN's National Planning Meeting (RAKERNAS) in March 1997.
- The Minister of Population and Chairman of the BKKBN has requested a follow-up study to examine the characteristics of 8 percent of 2,979 current and former NORPLANT® users interviewed in the survey. The findings will be presented together with the findings of a qualitative study, complementary to the survey, in 1997.
- The Population Council's ANE OR/TA conducted a follow-up analysis in June-July 1997 to compare the characteristics of women who did and who did not have NORPLANT® removed. Results suggest that priority for follow-up should be given to women in poor families, those over 40 years of age, those who want to limit births, those who did not go to school, and those who work outside the home.

Fisher, Andrew, Joedo Prihartono, Yayasan Kusuma Buana, and Jayanti Tuladhar. 1996. Indonesia NORPLANT® Removal Assessment Study. Jakarta: National Family Planning Coordinating Board (BKKBN); Department of Community Medicine, Medical School, University of Indonesia; and Population Council. July.

For further information or to obtain a copy of the final report, please contact Population Council, Tifa Building, Suite 404, Jl. Kuningan Barat No. 26, Jakarta, Indonesia 12710. Tel: 62-21-520-0094, 520-0494, Fax: 62-21-520-0232.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery. USAID support for this project was also provided through the Population's Council's Expanding Contraceptive Choice Program. Support was also provided by the World Bank.



IDENTIFYING GAPS IN DMPA METHOD COUNSELING

In Peru, inadequate counseling limits women's use of Depo-Provera (DMPA) and is a cause for concern even for the clients who continue to use it. The Ministry of Health is now training providers in counseling, with the goal of improving provider-client interaction and quality of services.

BACKGROUND

The Ministry of Health (MOH) has made Depo-Provera widely available in both rural health posts and urban clinics throughout Peru. However, the 1993 DHS survey noted that DMPA had the highest discontinuation rate at one year (68 percent) of any method offered. To learn more about the factors contributing to client satisfaction and dissatisfaction with DMPA, the MOH and the Population Council's INOPAL OR/TA Project conducted a qualitative study of users and discontinuers in coastal and Andean towns and nearby rural areas. Focus group discussions and in-depth interviews with 112 users and 38 discontinuers explored beliefs and knowledge relating to reproductive physiology, the menstrual cycle, the effects of DMPA, and their experiences with service providers. The study also included interviews with a small group of providers concerning their knowledge, attitudes and practices related to prescription of DMPA.

FINDINGS

Continuers

□ Many users receive distorted and incomplete information from service providers about reproductive physiology and about how DMPA works. Others discount what they are told because it is inconsistent with traditional beliefs. Many women who do not understand the information provided are reluctant to ask for more information, in part because of a lack of privacy. Providers often respond to concerns about amenorrhea by telling their clients that it is "normal" and not to worry about it.

Quotes from a Client and a Provider

"I would like to ask questions, but the nurses are always hurried, and what's more, there are many people and it makes me feel ashamed to be asking questions and saying my business out loud."

Luisa, 27 years old

"The women express their concern about amenorrhea. We tell them it is normal and causes no problem to their health, and they leave reassured."

Obstetrician at Hospital de Ilave, Puno

Source: Gárate et al., 1995

□ Approximately half of the continuers were less than 30 years old and all had been pregnant at least once. About 60 percent had some secondary education.

□ Traditional beliefs in the benefits of menstruation to a woman's health make even continuers fearful of the common DMPA side effect, amenorrhea. Many continuers worry that when they do not menstruate they are pregnant.

□ Users sometimes skipped an injection so that they would menstruate and be reassured that they were not pregnant.

Discontinuers

□ Discontinuers were slightly better educated, younger and had fewer children than continuers.

□ Amenorrhea was the most common reason cited for method discontinuation. Discontinuers feared that amenorrhea meant pregnancy, or believed that it could cause health problems. Other reasons cited for discontinuation included weight gain, headaches, and depression.

□ Some discontinuers reported that they did not understand the information service providers gave them; others felt that they did not receive enough information about side effects. Many discontinuers were still experiencing amenorrhea when interviewed and feared they were permanently sterile.

Providers

□ Providers often possessed erroneous information about DMPA. Many believed that it caused sterility or was appropriate only for women with three or more children. Paraprofessional providers were found to share many of their clients' traditional beliefs about the beneficial health effects of menstruation.

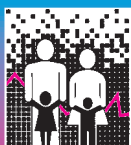
UTILIZATION OF RESULTS

□ The MOH has begun an extensive program to improve the quality of services including the client-provider interaction. The training emphasizes counseling on side effects.

Gárate, María Rosa, Manuela de la Peña, and Margarita Díaz. 1995. Estudio Cualitativo Sobre Inyectable Depo-Provera en Dos Regiones del Perú. Lima: The Ministry of Health and the Population Council. May.

For more information or to receive a copy of this report, please contact María Rosa Gárate, In-Country Advisor, INOPAL III, Population Council, Paseo Padre Constancio Bollar 225, El Olivar de San Isidro, Lima, Perú L-27, Tel: 51-14-42-04-48, Fax: 51-14-40-06-35, E-mail: postmast@pclima.org.pe.

This project was supported by the Population Council's INOPAL II and III Projects. INOPAL II and III are funded by the U.S. Agency for International Development (USAID), Office of Population, under DPE--3030-Z--00-9019-00, Project No. 936-3030 (INOPAL II) and Contract No. CCP-C-OO-95-00007-00 (INOPAL III), Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.



MAJOR TECHNICAL ASSISTANCE EFFORT PROVIDES TIMELY DATA ON REINTRODUCING DMPA

The government and other agencies are using the study's timely data on a pilot program reintroducing DMPA in the Philippines for program implementation and planning. About one-fourth of DMPA acceptors under the pilot program are first-time family planning users.

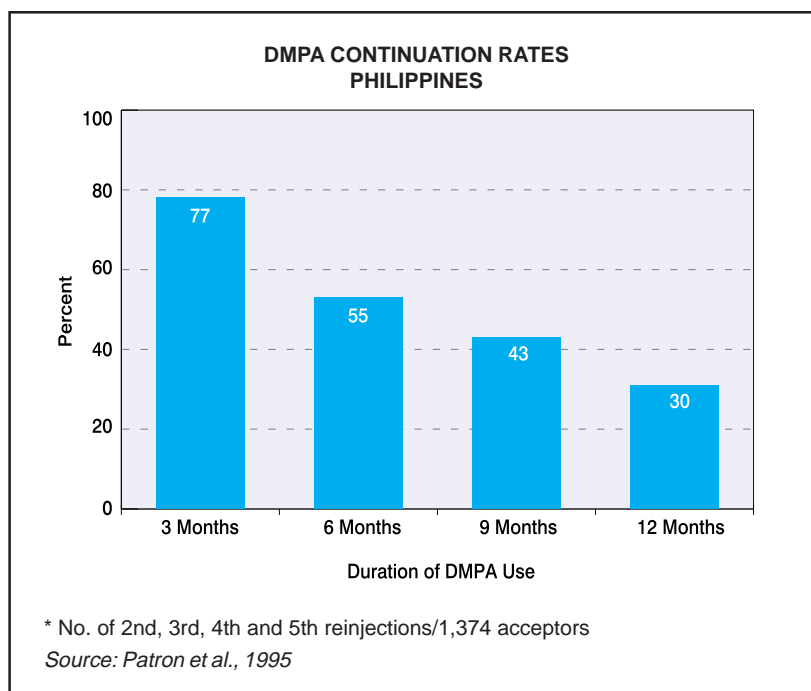
BACKGROUND

When the Department of Health (DOH) initiated the DMPA Reintroduction Program in April 1994, the method was available in few public health service sites and was accepted by less than one percent of family planning users. A total of 2,081 health facilities serving a population of about two million people in six provinces and four cities were selected for inclusion in the program. The Population Council provided technical assistance for program monitoring, including data on DMPA stocking, utilization, acceptance rates, and continuation rates. Five separate reports summarize the pilot program's results to date and provide qualitative information on service providers, DMPA acceptors, and the acceptors' male partners.

FINDINGS

□ A total of 1,748 trained providers, usually a female midwife, are providing DMPA services in 66 percent of all health facilities in the pilot area.

□ A total of 102,778 DMPA injections were dispensed between April 1994 and June 1995. Forty-eight percent of these were first injections. Most facilities averaged between three and four new acceptors per month.



□ The continuation rate per 100 new DMPA acceptors was 78 at three months, 53 at six months, 43 at nine months and 31 at 12 months (fifth injection).

□ The number of DMPA vials and syringes in stock per facility ranged from 16 to 112, suggesting a continuing need for logistics management. As of June 1995, 62 percent of health facilities had DMPA reminder cards in stock, and 56 percent had DMPA leaflets.

□ About 2 percent of married women of reproductive age in the pilot area now use DMPA compared to the national DMPA use rate of 0.1 percent prior to the reintroduction program.

□ The average DMPA acceptor was 29 years old, had attended high school, and had three children. Sixty-two percent of acceptors wanted no more children. For 27 percent, DMPA was the first family planning method they had ever used.

□ Nearly 80 percent of male partners were supportive of women's adoption of DMPA. Twenty-nine percent became less supportive as side effects, particularly irregular bleeding, were noted, but only 2 percent of women discontinued DMPA because of their partner's objections.

□ Ninety percent of women reported experiencing a side effect. Nausea/headache was the most common (46 percent), followed by spotting (40 percent) and weight gain (39 percent). One-fifth of them returned to the clinic to consult with the service provider, eight percent treated themselves and 71 percent did nothing.

UTILIZATION OF RESULTS

□ Reports and briefings on the OR results by the DMPA Task Force have been the principal source of information for DOH on DMPA reintroduction in the Philippines. The DOH has requested that the Population Council continue technical assistance on this issue for the next year to ensure continued availability of data on DMPA utilization.

□ The UNFPA and DOH have utilized the studies' estimates on expected demand, based on the number of supply sites, acceptance and continuation rates, in developing their DMPA procurement plans.

Patron, Maria Carmel, and Marilou Palabrica-Costello. 1995. Experience with the DMPA Injectable Contraceptive: Findings from a Survey of DMPA Acceptors. Manila: Department of Health and the Population Council. August.

---- 1995. The DMPA Service Provider: Profile, Problems and Prospects. Manila: Department of Health and the Population Council. August.

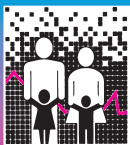
---- Knowledge, Attitudes and Practice of the DMPA Injectable Contraceptive: Data from Focus Group Discussions. Manila: Department of Health and the Population Council. August.

---- DMPA Monitoring Study, Final Report. Manila: Department of Health and the Population Council. August.

Arenas, Myra L. and Marilou Palabrica-Costello. 1995. Experience with the DMPA Injectable Contraceptive: A Comparison between Continuing-Users and Drop-Outs. Manila: Department of Health and the Population Council. August.

For more information on these studies or to receive a copy of the final reports, please contact the Population Council, Monteverde Mansions, Unit 2A3, 85 Xavier Street, Greenhills, San Juan, Metro Manila, Philippines. Tel: 63-2-784-475, Fax: 63-2-721-2786.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.



VASECTOMY: A NEW REPRODUCTIVE HEALTH OPTION FOR MEN

This study found that men in Dar es Salaam reacted positively to the promotion and introduction of vasectomy services by two Tanzanian NGOs. The findings contributed to development of a strategic plan to expand a full range of FP services, with a special emphasis on longterm and permanent methods, nationwide.

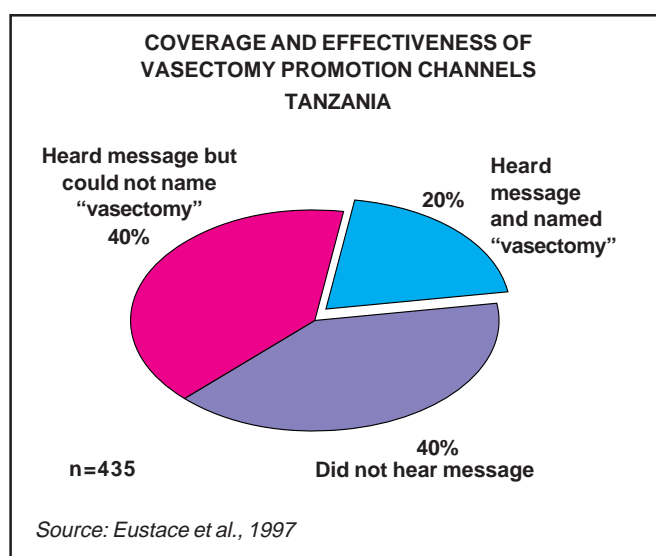
BACKGROUND

Until recently, vasectomy was virtually unknown in Tanzania. The lack of a supply of and demand for vasectomy services was blamed on negative male attitudes toward taking responsibility for family planning and the perception that vasectomy was equivalent to castration. The Population Council's Africa OR/TA Project studied the extent to which a six-month project by two Tanzanian FP organizations, Population and Health Services (PHS) and the Tanzania Family Planning Association (UMATI), was effective in providing knowledge, fostering favorable attitudes and creating demand for vasectomy in Dar es Salaam. Their pilot project featured four main interventions: promotion on radio, television and newspapers; informational posters and leaflets; talks given to men at workplaces; and training of vasectomy counselors and surgeons at 5 PHS and UMATI clinics. The OR study comprised a survey of the male population in Dar es Salaam and Situation Analysis and Mystery Client studies of the quality of counseling and information services offered at the family planning clinics involved in the vasectomy promotion.

FINDINGS

□ The vasectomy promotion activities were successful in reaching a majority of men in Dar es Salaam. Sixty percent of men reported hearing at least one message during the promotion period. But comprehension of the message was much lower; only one-third of men who had heard the message could recall the term "vasectomy."

□ More than half the men who were exposed to the Vasectomy Promotion Project had at least one positive attitude toward vasectomy. These men rejected the notion that vasectomy amounts to castration or reduced a man's sexual potential, disagreed that sterilization was acceptable for women but not for men, and agreed that vasectomy improves the sexual relations of partners.



- One-fourth of the respondents reported they would consider vasectomy when they had all the children they wanted. Five percent said they had made special efforts to learn more about vasectomy.
- One-third of the men who heard a talk about vasectomy during the promotion period later discussed vasectomy with friends or relatives.
- Few respondents knew where to go for vasectomy services and mystery clients found it difficult to reach some of the facilities.
- While 95 men sought more information at the five participating clinics and received counseling about vasectomy during the project, only 11 men actually received a vasectomy.
- Facilities for providing vasectomy information and counseling were often inadequate. Only one-half of the service providers in the project clinics had been trained in counseling for vasectomy; audio and visual privacy during counseling was lacking, and all concerns of the mystery clients were addressed in less than half of the counseling sessions.
- More than half of the men interviewed reported an ideal family size of four or fewer children. More than two-thirds rejected the notions that a large family is prestigious and that many children are helpful in providing old age security.

UTILIZATION OF RESULTS

- The results of this activity are contributing to the introduction of vasectomy services in other urban centers of Tanzania.
- Drawing on these findings, PHS has already developed a strategic plan to expand a full range of family planning services, with a special emphasis on longterm and permanent methods including vasectomy, to 21 service delivery points nationwide.

Eustace Muhondwa, Naomi Rutenberg and Grace Lusiola. 1997. Effects of the Vasectomy Promotion Project on Knowledge, Attitudes and Behavior in Dar es Salaam, Tanzania. Nairobi: the Population Council. June.

For more information or to receive a copy of the report, please contact the Africa OR/TA Project II, Population Council, P.O. Box 17643, Nairobi, Kenya, Tel: (254)(2)713-480, Fax: (254)(2)713-479, E-mail: ORTA@popcouncil.or.ke.

This project was supported by the Population Council's Africa Operations Research and Technical Assistance Project II. The Africa OR/TA Project II is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-3030-C-00-3008-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

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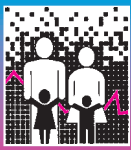
POSTABORTION CARE



Julie Solo (Africa OR/TA Project)

Postabortion care is an integral part of women's reproductive health services, and an important strategy for reducing maternal mortality and morbidity. For many women, treatment for postabortion complications can be a difficult and painful experience. However, new models of **postabortion care** are emerging that replace sharp curettage (D&C), usually performed under a general anesthetic, with outpatient manual vacuum aspiration (MVA). They also integrate this improved treatment with counseling and the provision of family planning services. Emerging issues include client counseling, pain control, involving men as partners and home care following treatment.

Operations research in **postabortion care** has focused on testing the efficacy, cost-effectiveness, and quality of the new **postabortion care** models. OR has also been useful in providing an orientation to policy and program issues related to postabortion program implementation.



POSTABORTION CARE: COUNSEL HUSBANDS AS WELL AS PATIENTS

Postabortion patients and their families in Egypt have major concerns about the women's future fertility. Joint counseling sessions for husbands and wives could help remove apprehensions and inform couples of the woman's almost immediate return to fertility and the need to use a contraceptive method.

BACKGROUND

This study, conducted by the Population Council, investigated the concerns of postabortion patients in Egypt in order to improve the counseling these women receive. The study's objectives were three-fold: decrease the risk of mortality and morbidity associated with incomplete abortions, increase postabortion patients' use of family planning, and use the information gathered in the production of counseling materials and in development of culturally sensitive survey questioning techniques on abortion in Egypt. The research team conducted in-depth interviews with 31 women hospitalized following an abortion and focus group discussions with family planning clients.

FINDINGS

□ In this sample, the average postabortion patient is between 25 and 35 years old, with three children. The majority do not work outside the home and have minimal formal education.

□ About one-third of the patients have never used contraception. Only 16 percent were currently using a family planning method at the time of conceiving the pregnancy they had just lost. About one-third of pregnancies were planned.

□ The women and their families have major concerns about the women's future fertility. They are preoccupied by the causes of the abortion and the actions they can take to reestablish 'bodily order'.

Concerns of Postabortion Patients In Egypt

"To get back to her normal condition, a woman needs a proper diet and a place to relax and rest. But how can I get that? Where I come from (a rural area) women have to work hard..."

"Having an abortion affects the women's fertility. She has to stay for a long time until she gets pregnant again..."

"This is the first time for me to have an abortion, but thank God, we do not want any more children. I really did not want to have this pregnancy..."

"I feel severe pain with every move I make... This has been the most painful experience I have ever had."

"Many women go through a lot of psychological pain, especially if the husband is not appreciative of the situation...Many husbands think that women induce the abortion."

Source: Huntington et al., 1995

- Many women expressed apprehensions about contraceptive use following abortion, fearing that it could inhibit restoration of reproductive health. On the other hand, they stated that it is important to avoid another pregnancy in the near future.
- Almost all postabortion patients are accompanied to the hospital by one or more family members. Husbands often accompany patients on admission or come to the hospital at discharge.
- Women arrived at the hospital for postabortion treatment in a state of heightened anxiety due to physical pain and discomfort, and substantial hemorrhaging. All patients interviewed were alarmed about the implications of the bleeding on their recovery and future health.
- Multiple economic pressures and family obligations prohibit many women from enjoying a full recuperation period. Recovery is further hindered by fear of the social and family stigma attached to failing to carry a fetus to term.
- Spousal support can be a vital factor in the emotional as well as physical healing of the patient. Most patients readily support the idea of counseling for their husbands about care during recovery and return to fertility.

RECOMMENDATIONS

- The husband should be advised about the trauma experienced by his wife and the importance of a recuperation period. A male physician could be the most appropriate counselor for spouses. Such sessions should take place before the woman leaves the hospital.
- Joint counseling sessions where husband and wife receive information about the woman's ability to conceive and carry to full term another pregnancy could help remove any apprehensions about their ability to achieve their desired family size.
- Postabortion women should receive clear and careful explanations about how the postabortion period is different from the postpartum period, in particular stressing the almost immediate return to fertility and the need for a contraceptive method.

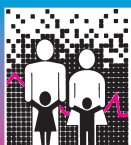
UTILIZATION OF RESULTS

- A program is now being developed to institutionalize postabortion medical services in Egypt over the next three to five years by creating linkages between the consortium of medical universities training students in MVA clinical procedures and public and private family planning services.
- The findings of this study support and update the current research on the procedures and contents for counseling postabortion women and their husbands in Egypt.
- Study results are being used in developing counseling curricula and thus will be used in implementing the strategy for improving postabortion care in Egypt.

Huntington, Dale, Laila Nawar and Dalia Abdel Hady. 1995. Exploratory Study of Psycho-social Stress Associated with Abortion in Egypt. Cairo: the Population Council. September.

For further information on this study or to obtain a copy of the final report, please contact the Population Council, 6A Giza St., P0 Box 115, Dokki, Cairo-12211, Egypt. Tel: 5738277, Fax: 5701804.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance (ANE OR/TA) project. The ANE OR/TA project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.



IMPROVING POSTABORTION QUALITY OF CARE

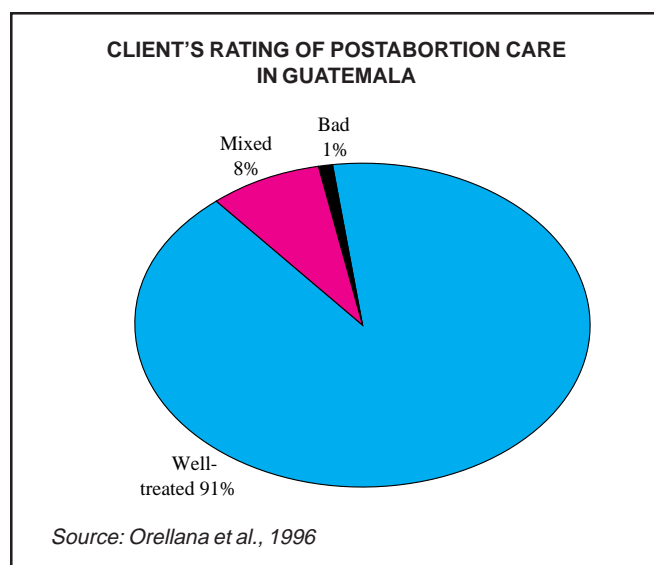
The Guatemalan Social Security System (IGSS) offers integrated postabortion care. However, the quality of services was hampered by limited patient counseling and limited contraceptive availability. Study results led to improved information for clients and increased availability of contraceptive methods.

BACKGROUND

Presently, only a few health care systems in Latin America have integrated family planning services into their provision of postabortion care. One place where integration has taken place is a large Social Security Institute (IGSS) hospital in Guatemala City which treats 150 postabortion women every month. With assistance from the Population Council's INOPAL OR/TA Project, IGSS conducted a study to examine the quality of postabortion care provided, including: 1) client-provider interaction, 2) information given to the client, 3) contraceptive availability, and 4) provider's ability to diagnose infections at the time of admission, as diagnosis of infection is a contraindication for insertion of an IUD immediately postabortion. The study sample was 304 postabortion women, diagnosed at admission as not infected. They were asked at discharge to return for a check-up and an interview within three to five days. To facilitate their return, they were offered 50 quetzales (about US\$8.00), to defray visit costs. Returning women who participated in the study were interviewed about their experience in-hospital and were examined for evidence of infection. Non-users of family planning were offered information and contraception.

FINDINGS

□ Approximately 91 percent of women reported being “well-treated” during the postabortion experience; about 8 percent said treatment was “mixed,” and 1 percent rated it “bad.” The most common reason for dissatisfaction was the length of waiting time in the emergency room before admission. Most women experiencing long waits were being kept under observation by providers, a fact that may not have been adequately explained to them.



- Postabortion treatment at the hospital consisted of dilation and curettage (D&C) followed by hospitalization. Contraceptives available in-hospital were limited, before the study, to the IUD and minilaparotomy. Women desiring other methods could only receive them if they returned for a check-up, routinely scheduled for three to six weeks after hospital discharge.
- About 88 percent of the 304 sampled women received in-hospital family planning information, and 25 percent received an IUD. The remaining 149 who were given information did not receive a contraceptive method, although 124 stated they would have preferred to receive a method pre-discharge. About 82 percent of non-users accepted a method at the follow-up visit, mainly DMPA. No women were sterilized.
- Two-thirds of the 304 women returned. Under normal circumstances only about 25 percent of postabortion women return for a check-up. As intended, the payment produced a much higher return rate than usually encountered among postabortion women. About 68 percent of those returning were ages 20 to 35, 20 percent were over 35, and 12 percent less than 20.
- Only a few women knew the symptoms of postabortion complications or how soon fertility returned following an abortion.
- At the check-up, 15 percent had a pelvic infection, including 5 of 51 IUD users (10 percent) and 25 of 149 non-family planning users (17 percent). The small difference in infections encountered suggests that infection status usually cannot be detected or predicted by IGSS personnel at the time of admission.

Implications of Findings

- It may be worth considering delaying insertion for, or providing antibiotics to, women receiving IUDs.
- Since few women return for postabortion visits, strategies for increasing the return for postabortion checkups should become a national priority.

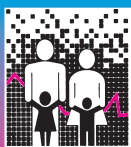
UTILIZATION OF RESULTS

- As a result of the study, IGSS increased in-hospital contraceptive availability to include hormonal and barrier methods, and published patient information materials.

Orellana, Maria Lobos, Gustavo Gutierrez, Carlo Bonatto, and Emma Ottolenghi. 1996. Calidad de Servicios Dirigidos a las Mujeres Que Cursaron con Aborto: Hospital Gineco-Obstetricia IGSS. Guatemala City: Hospital Gineco-Obstetricia IGSS and the Population Council.

For more information or to obtain a copy of the report, please contact Jim Foreit, Director, INOPAL III, Population Council, 4201 Connecticut Ave, NW, Suite 408, Washington, DC 20008, USA, Tel: (202)237-6455, Fax: (202)237-6458, E-mail: inopal@pcdc.org.

This project was supported by the Population Council's INOPAL III Project. INOPAL III is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-C-OO-95-00007-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery. Technical and financial assistance was provided to IGSS by the Population Council's Program Development Fund.



IDENTIFYING UNMET NEED FOR POSTABORTION CARE

A diagnostic study of the services currently provided to women attending hospitals for the treatment of complications due to spontaneous or induced abortions shows a largely unmet need for more comprehensive services and scope for improvement in the quality of care provided.

BACKGROUND

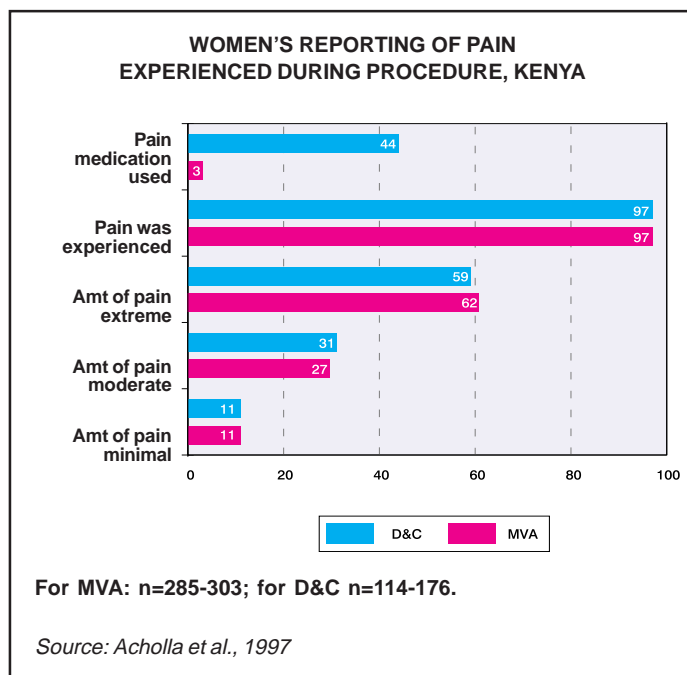
Hospital-based studies in Nairobi have shown that unsafely induced abortion accounts for as much as 35 percent of pregnancy-related mortality and at least 50 percent of hospitals' gynecological admissions. In collaboration with IPAS, the Kenyan Ministry of Health (MOH), and the Family Planning Association of Kenya (FPAK), the Population Council's Africa OR/TA Project is testing three different models linking emergency treatment of incomplete abortion and FP services in six MOH hospitals. Study methodology includes collecting pre-intervention data; carrying out an intervention consisting of training, facility upgrades, and reorganization of services; and collecting post-intervention data. Researchers interviewed 481 patients and 140 staff at six public hospitals in Kenya to establish an understanding of the current treatment of women admitted for postabortion complications.

FINDINGS

□ Only one-fifth of all patients received pain medication before or during the procedure. Of the women who were awake during the procedure, almost all reported experiencing pain. Two-thirds indicated that the pain was "extreme."

□ The staff perceived their patients to be mainly young, unmarried girls trying to delay their first full-term pregnancy. Patient interviews revealed, however, that over 60 percent were aged 20-29 years and 71 percent were married.

□ Although, as an outpatient procedure, manual vacuum aspiration (MVA) requires less time to administer than dilation and curettage (D&C), patients attending hospitals which use MVA tended to wait longer for treatment than those attending hospitals using D&C.



- Infection prevention was found to be less than satisfactory, due both to a lack of supplies and incorrect practices by staff.
- Almost half the providers described their relations with the patients as “poor,” one-third felt they were “good,” and 15 percent said “it depends,” as they often differentiate between women attending for spontaneous and induced abortions.
- Less than one-fifth of patients were given any information about the treatment procedure, their general health status, or their return to fertility.
- At five hospitals, only 7 percent of patients reported receiving any FP information, but virtually all said they would have liked to receive such information. Only 22 percent decided to begin using contraception at the five hospitals, and of these, only 3 percent received their method before discharge. At the sixth hospital, staff had already begun to implement a comprehensive postabortion care service and 98 percent of patients received family planning counseling.

UTILIZATION OF RESULTS

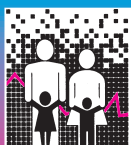
- The results from this baseline survey were used during a two-day joint planning workshop for implementation of the comprehensive postabortion care models to be tested at each hospital.
- Training in MVA and FP counseling for postabortion patients completed at the six hospitals incorporated study results, including provider-suggested ways in which pain could be reduced, the need to separate personal biases from their treatment practices, and the need to provide counseling to women before, during and after the procedure.
- To address providers’ negative attitudes toward patients with complications from induced abortion, a forum was set up for staff dialogue, supplies were improved and pay was increased. Providers were trained, at their request, in practices regarding infection prevention in the handling of MVA equipment.
- Hospitals that had been treating patients in main or shared theaters, which caused long waiting times for treatment, have created rooms on the gynecological ward to treat incomplete abortion patients.

Acholla, Ominde, Margaret Makumi, Deborah Billings, and Julie Solo. 1997. Postabortion Care Services in Kenya: Baseline Findings from an Operations Research Study. Nairobi: the Kenyan Ministry of Health (MOH), the Family Planning Association of Kenya (FPAK), IPAS, and the Population Council. March.

For more information or to obtain a copy of the final report, please contact the Africa OR/TA Project II, Population Council, P.O. Box 17643, Nairobi, Kenya. Tel: (254) (2) 713-480; Fax: (254) (2) 713-479; E-mail: ORTA@popcouncil.or.ke.

This project was supported by the Population Council's Africa Operations Research and Technical Assistance (OR/TA) Project II. The Africa OR/TA Project II is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-3030-C-00-3008-05, Project No. 936-3030. Strategies for Improving Family Planning and Reproductive Health Service Delivery.

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IMPROVING CARE OF POSTABORTION PATIENTS IN HOSPITALS

This study of the treatment of incomplete abortion patients in Kenya obtained baseline information for planning the integration of treatment of abortion complications and family planning services in Kenyan hospitals. The findings were used to design three different models for improving postabortion care.

BACKGROUND

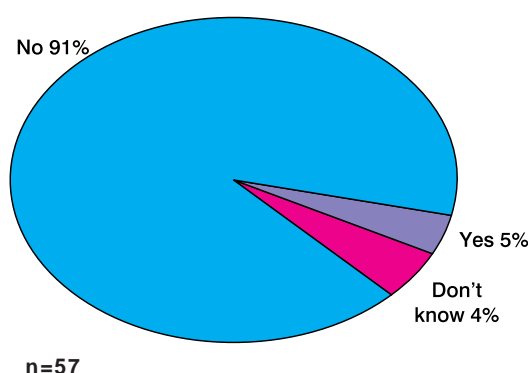
The Population Council's Africa OR/TA Project and the Robert H. Ebert Program on Critical Issues in Reproductive Health and Population are working in close collaboration with IPAS, the Kenyan Ministry of Health, and the Family Planning Association of Kenya (FPAK) to test alternative models for providing improved postabortion care in Kenya. Evidence suggests that Kenya has a high rate of repeat abortion. Although FP services are available in the public institutions where management of incomplete abortion takes place, these two services are largely segregated from each other. This study examined emergency treatment services for postabortion patients; postabortion FP counseling and services; and the links between emergency abortion treatment services and comprehensive reproductive health care in 18 Kenyan hospitals.

FINDINGS

□ Annual caseloads for the treatment of incomplete abortion at the 18 hospitals, drawn from 1993 records, ranged from a low of 113 to a high of 1,101, with an average of 482 cases per hospital. Provider estimates of their caseloads were much higher than their records showed. Since records were often only partially completed, poorly organized and not centralized, the numbers from the records were most likely an undercount of the true figures.

□ Eighty-six percent of the service providers interviewed thought that their patients should always be given family planning information while still in the hospital. However, 91 percent said that incomplete abortion patients are not routinely given family planning information or offered services.

ARE INCOMPLETE ABORTION PATIENTS
ROUTINELY GIVEN FP INFORMATION?
KENYA



Source: Solo et al., 1995

- Almost two-thirds of the postabortion care providers suggested that FP counseling be done on the ward. As for the provision of methods, 64 percent indicated that the methods should be provided at the FP clinic, since the clinic already has a system in place to provide for follow-up of FP clients.
- Of the 75 providers interviewed, 95 percent indicated that the current postabortion services could be improved. Areas cited for improvement include increasing supply of antibiotics, gloves, disinfectant, specula, and MVA equipment; improving the blood bank; adding staff; and giving prompt attention to patients.
- Treatment of uncomplicated incomplete abortions through manual vacuum aspiration (MVA), rather than sharp curettage (also known as D&C), was used at 11 of the 18 hospitals. The most common reason cited for not using MVA was the lack of equipment or expendable supplies, such as disinfectant.
- A number of providers had negative or judgmental attitudes toward incomplete abortion patients.
- Family planning services are offered in all 18 hospitals visited. On average, each hospital saw 86 new FP clients and 546 revisiting clients each month. Hospitals generally have 7 to 8 FP methods available and in stock.
- Although the hospitals are set up to provide family planning services, minimal linkages were found between the treatment of incomplete abortion patients and family planning information and services. Few postabortion patients actually receive FP services.
- More than two-thirds of family planning providers interviewed felt that FP counseling should be offered to postabortion patients on the ward.

UTILIZATION OF RESULTS

- The study results are being used to plan for the introduction of three hospital-based interventions that will enable development of a direct link between postabortion treatment and family planning counseling with the goal of improving the quality of both postabortion treatment and family planning services. The three interventions are: a) providing family planning on the gynaecological ward by ward nurses; b) providing family planning at the MCH/FP clinic; or c) providing family planning on the gynaecological ward by the MCH/FP staff.

Solo, Julie, Esther Muia, and Khama Rogo. 1995. Testing Alternative Approaches to Providing Integrated Treatment of Abortion Complications and Family Planning in Kenya: Findings from Phase I. Nairobi: the Population Council and the Centre for the Study of Adolescence. August.

For more information or to receive a copy of the report, please contact Julie Solo, Africa OR/TA Project II, Population Council, P.O. Box 17643, Nairobi, Kenya, Tel: (254)(2)713-480, Fax: (254)(2)713-479, E-mail: ORTA@popcouncil.or.ke.

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IMPROVING POSTABORTION SERVICES IN THE MEXICAN HEALTH SYSTEM

A study seeking to humanize the postabortion procedure in Mexico, provided information about the fear, pain, and waiting times endured by women seeking treatment for incomplete abortion, and demonstrated the high health system costs of the procedure. Procedures, counseling and quality of care have been improved.

BACKGROUND

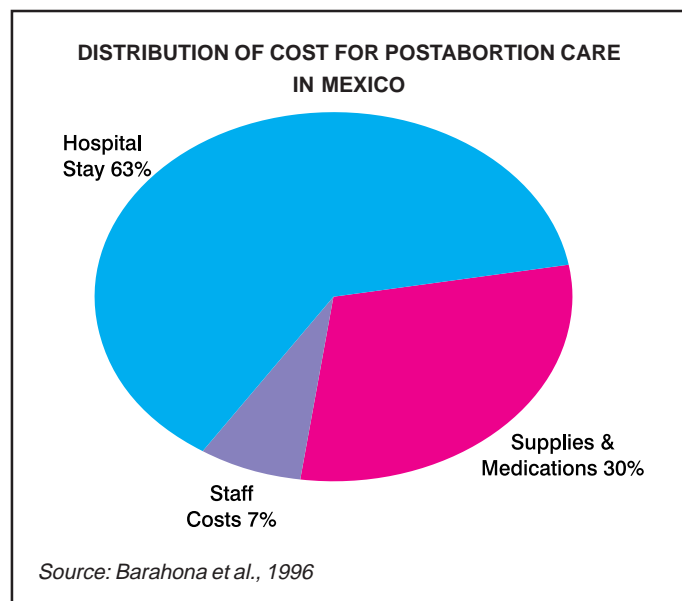
An estimated four million abortions take place annually in Latin America, and complications from the procedure are among the region's primary causes of maternal morbidity and mortality. The Dr. Aurelio Valdivieso General Hospital in Oaxaca, in conjunction with the Population Council's INOPAL OR/TA Project and IPAS, carried out a study to assess the quality of postabortion services provided through the hospital and train health providers in the use of safer medical techniques and better FP counseling and services. Researchers interviewed and examined the medical records of 132 postabortion patients and interviewed service providers. The study developed a profile of the women who come to the hospital with incomplete or complicated abortions, and provides information on the quality of care provided.

FINDINGS

□ The average cost per postabortion case at the hospital is \$192. The major costs are related to the practice of hospitalizing women after postabortion treatment.

□ One-third of the women are illiterate or semi-literate. Roughly 80 percent depend economically on their male partners. For one-fourth, this was a first pregnancy; for one-third, it was at least their fifth pregnancy. Seventeen percent reported having a previous abortion. One-third did not want this pregnancy, and 19 percent said they were using a contraceptive method when the pregnancy occurred.

□ Sixty-five percent of patients spent six hours or more waiting for emergency treatment.



- Forty-five percent of the women felt “very fearful” upon arrival at the hospital. The most common fears mentioned included the operation and anesthesia (48 percent), bleeding (27 percent), pain (22 percent), and death (18 percent). Seventy percent of the women reported feeling even more afraid after the receiving physician examined them.
- In spite of the fact that 58 percent of the women reported feeling great pain, none of them were given an analgesic prior to entering the operating room. After the procedure, 40 percent reported pain, and about 28 percent received some form of pain medication.
- Prior to treatment, one-third of the women were not informed of their diagnosis, 12 percent were not aware of the type of treatment planned, and only 13 percent were asked if they had any questions. The main reasons they did not ask questions were: 1) it did not occur to them; 2) they were afraid to bother the physician; or 3) they were too embarrassed.
- More than three-fourths received no information in the recovery room about the state of their health. Approximately 96 percent received no information about post-treatment medication, warning signs of possible complications, or what to do in case of an emergency.
- Fifty-eight percent of women did not receive any family planning information. Of the 42 percent who did receive information, 70 percent accepted a method, but nearly half of acceptors did not receive their preferred method.

UTILIZATION OF RESULTS

- Project staff used the study results to help design an intervention to improve quality of care. A follow-up study is planned.
- Hospital staff participated in the development of strategies to improve service delivery. Strategies included: adopting standardized protocols for postabortion treatment and routine provision of family planning counseling and methods; staff training in manual vacuum aspiration (MVA) and provider–patient relations; development of a series of IEC pamphlets on complications for patients; and development of a series of posters for providers on interpersonal relations.

Barahona, Vilma, Beatriz Casas, Francisca Ramirez, Felipe Perez Sainoz, Aurelio Valdivieso, Jose David Ortiz Mariscal, Andrea Saldala, Cecilia Garcia Barrios, Ana Langer Glas. 1996. Estimating Cost of Postabortion in General Hospital Aurelio Valdivieso, Oaxaca. Mexico City: Aurelio Valdivieso General Hospital, IPAS and the Population Council. September.

For further information or to receive a copy of this study, please contact Carlos Brambila, Program Associate, INOPAL III, Population Council. Escondida 110, Col. Villa Coyoacan, 04000, Mexico, D.F., Mexico, Tel: 52-5-659-8541, Fax: 52-5-554-1226, E-mail: cbrambila@laneta.apc.org.

This project was supported by the Population Council's INOPAL III Project. INOPAL III is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-C-OO-95-00007-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

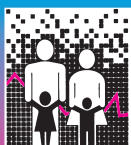
RTIs, STIs, AND HIV/AIDS



Bernard P. Wolff (Unicef)

Reproductive tract infections (RTIs), and sexually transmitted infections (STIs) in particular, are a major health problem around the world. The prevalence of **RTIs** among clients of maternal health and family planning programs, and a woman's increased likelihood of contracting HIV/AIDS if she is infected with an RTI, demand that programs detect and treat infections among their clients, and inform their clients of ways to identify and prevent infection. Providing these services poses a significant challenge to program managers and service providers.

Operations research on **RTIs, STIs and HIV/AIDS** has focused on assessing alternative strategies for integrating RTI/STI screening, and integrating treatment and prevention activities into existing primary health care and family planning services. Community education, effective case management, and care of partners are critical issues for service delivery.



STRENGTHENING THE INTEGRATION OF STI/HIV AND MCH/FP SERVICES

A case study that assessed the addition of STI/HIV services into the existing MCH/FP activities of an NGO program in Mombasa, Kenya led to a better understanding of how to offer an integrated reproductive health care service and to significant improvements in the quality of care provided.

BACKGROUND

Data from the National Sentinel Surveillance system show that the prevalence of HIV infection among women attending antenatal services in Mombasa rose from 10 percent in 1990 to 16 percent in 1993. The Mkomani Clinic Society (MCS), a non-governmental organization (NGO) based in Mombasa, Kenya, supported two primary health care SDPs with on-site laboratories, and a community outreach program with 30 full-time Community Service Workers (CSWs). With technical assistance from Pathfinder International, in 1992 MCS began to integrate STI screening and treatment services and HIV education into routine MCH/FP service delivery activities, and MCS developed a model for providing integrated services. The Population Council's Africa OR/TA Project undertook a case study to document how the model functions so that lessons could be passed on to others interested in providing STI case management and HIV education and screening within an MCH/FP setting. The study also highlighted areas in which the quality and efficacy of the model can be strengthened.

FINDINGS

□ Most MCS staff have not attended any formal training courses on STI and HIV/AIDS management, but MCS has organized in-house training sessions for all staff. Although many staff understood the key concepts of providing an integrated service, most did not fully implement such key elements as risk assessment and screening when providing services to MCH/FP clients.

□ There were no formal guidelines, protocols or service manuals to assist staff in implementing the integrated activities.

The Mkomani Clinic Society Integration Model

- Routinely carry out a risk assessment for STI/HIV/AIDS among all clients visiting the SDPs for FP, antenatal and child welfare services;
- Provide information on STI/HIV to all clients;
- Inform the public about STIs and HIV/AIDS and the availability of services;
- Protect health personnel and MCH-FP clients from infection;
- Test all ANC clients for syphilis;
- Diagnose and treat common STIs within the MCH/FP unit;
- Identify and refer all clients with symptoms and signs of HIV infection, or those requesting HIV testing;
- Carry out contact tracing, and risk assessment, screening, diagnosis and treatment for the contacts.

Source: Twahire et al., 1996

- Both SDPs have an adequate supply of basic equipment and other requirements for providing STI and HIV/AIDS services in addition to MCH/FP services. The only deficiency is waste disposal facilities.
- The physical infrastructure at both SDPs does not facilitate client flow between services, group IEC activities, or provide for adequate client privacy.
- IEC materials on STIs and HIV/AIDS for use in the SDPs and in their community-based activities are lacking.
- Staff need further training to clarify the differences between STI risk assessment and the syndromic approach to diagnosis and treatment of STIs.
- Contacting sex partners with STIs continues to be a major problem.
- Cost analysis undertaken concurrently with the case study found that it costs the MCS US\$ 8.20 to provide an STI service, yet the client pays US\$ 4-5. It is difficult to raise user fees beyond this, so the difference has to be raised from other sources like donors and charitable fundraising activities.

UTILIZATION OF RESULTS

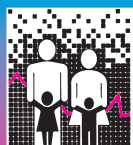
- A service provider instruction manual for STI case management has been developed and introduced. The manual has been used for monitoring and supervising the quality of services.
- Changes have been made in the physical layout of the clinics to reduce overcrowding in the waiting areas and enhance clients' privacy during consultations.
- The information gained from the case study and cost analysis has encouraged MCS to re-examine its cost-recovery and funding mechanisms to look for ways of becoming more financially sustainable.

Twahir, Amina, Baker Ndugga Maggwa and Ian Askew. 1996. Integration of STI and HIV/AIDS services with MCH/FP services: A case study of the Mkomani Clinic Society in Mombasa, Kenya. Nairobi: Mkomani Clinic Society and the Population Council. April.

For more information or to receive a copy of the final report, please contact the Africa OR/TA Project II, Population Council, P.O. Box 17643, Nairobi, Kenya. Tel: (254) (2) 713-480; Fax: (254) (2) 713-479, E-mail: ORTA@popcouncil.or.ke.

This study was supported by the Population Council's Africa Operations Research and Technical Assistance Project II. The Africa OR/TA Project II is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-3030-C-00-3008-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

January 1998



INTEGRATING STI/HIV SERVICES INTO EXISTING MCH/FP PROGRAMS

STI and HIV/AIDS management services can be integrated successfully into existing MCH/FP programs in East and Southern Africa. A prototype model common across different types of service delivery programs appears to be emerging.

BACKGROUND

The presence of certain STIs increases the risk of the sexual transmission of HIV. Thus, controlling STIs can significantly reduce the incidence of HIV. Almost all women in the East and Southern African regions attend MCH/FP clinics regularly, and recent surveys have shown that the prevalence levels of many STIs, including HIV, can be high for women seeking FP and antenatal services, despite the fact that they are frequently asymptomatic. MCH/FP services are provided by medically trained staff with many of the same skills needed for managing STIs. Consequently, several MCH/FP programs have started looking for ways to integrate STI management strategies, such as STI screening, treatment and education, into their routine services. The Population Council's Africa OR/TA Project undertook case studies of four such programs: one national (Botswana); one municipal (Nakuru, Kenya); one NGO (Mombasa, Kenya); and one church-based (Busoga, Uganda). The model includes: case detection and treatment, HIV/AIDS management, detection and treatment of syphilis, and information and education materials.

FINDINGS

□ Risk assessment and clinical history taking are essential for detecting STI cases among mainly asymptomatic MCH/FP clients, but neither are being performed consistently or according to guidelines.

□ The syndromic approach has been adopted for detecting STIs because of its applicability at most MCH/FP clinics, where laboratory testing is not possible, but this approach has not always been correctly applied.

A Prototype Model for Integrated Services

1. Case detection and treatment of asymptomatic women

Assess risk; take clinical history; perform general exam; perform pelvic exam; categorize any signs or symptoms into general syndrome, and provide curative treatment; encourage contact tracing.

2. HIV/AIDS management

Refer clients with signs and symptoms to nearest specialist site; refer clients who request testing; provide IEC on prevention of HIV transmission and signs/symptoms of infection to all clients.

3. Detection and treatment of maternal syphilis

Screen all antenatal clients on first visit through referral or on-site test; encourage contact tracing.

4. Information and education to prevent new infection and improve health-seeking behavior

Raise awareness of signs and symptoms of infection; educate on safer sexual practices; promote condom use; give health talks; make print materials available in waiting room and during consultations; give talks within the SDP catchment area; advertise availability of services.

Source: Maggwa et al., 1997

- Clients' awareness of symptoms and signs associated with STIs, their ability to identify and describe them, and the providers' capacity to understand clients' descriptions need to be improved for the syndromic approach to work effectively.
- The syndromic approach is intended to simplify treatment of STIs by requiring a small range of drugs that can treat several types of infection. The supply of these drugs at clinics and their purchase by clients are major problems in all but the strongest programs.
- The procedure followed for contact tracing (i.e. asking the woman to notify her partner and to visit the clinic) was found to be universally weak, thus increasing the woman's risk of reinfection.
- The model developed is appropriate for MCH/FP service delivery points with limited or no access to laboratory facilities. The integrated service is offered as a package of services in a single visit, primarily to new family planning clients and to antenatal clients.
- MCH/FP clients suspected to have HIV, or who have asked for a test, are referred to specialist clinics for testing and counseling.
- All programs have mandatory syphilis screening for antenatal clients. Because this normally requires the client to return at a later date for the result, and it requires payment, few women have the test and fewer return for the result.
- Condom promotion is expected to be an integral component of all information exchanges with clients but is undertaken to differing extents by each program. For example, the Uganda study found that only 25 percent of new FP clients were asked about condom use, and in the Kenya study, less than 7 percent of MCH/FP clients were informed about the role of condoms in reducing the rate of STI and HIV transmission.

UTILIZATION OF RESULTS

- Results were used to guide development of OR studies on integration in other African countries, including Kenya, Zimbabwe, Ghana and Burkina Faso.

Maggwa, Baker Ndugga and Ian Askew. 1997. Integrating STI/HIV Management Strategies into Existing MCH/FP Programs: Lessons from Case Studies in East and Southern Africa. Nairobi: the Population Council. June.

For more information or to receive a copy of the report, please contact the Africa OR/TA Project II, Population Council, P.O. Box 17643, Nairobi, Kenya. Tel: (254) (2) 713-480; Fax: (254) (2) 713-479, E-mail: ORTA@popcouncil.or.ke.

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January 1998

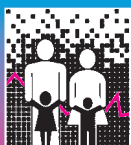
GENDER AND EMPOWERMENT



Shari Kessler (ANE OR/TA Project)

Gender is a social construct that influences an individual's perception of self, and social roles in family and society. **Empowerment** relates to individuals' understanding of their own needs, control over the use of family planning, and the power to make decisions that affect sexuality and their reproductive health. These topics are important determinants of women's and men's behavior as parents, decision makers, and sexual partners. A better understanding of **gender and empowerment** considerations can help program managers and policy makers improve reproductive health services and increase men's partnership in family planning and welfare.

Operations research on **gender and empowerment** has focused on analyzing gender roles and their impact on the use of family planning services, the partnership of men in reproductive health and social perspectives on fertility, sexuality and care of children.



FAMILY PLANNING ENHANCES WOMEN'S STATUS

Family planning programs can act as a stimulus for the spread of new ideas, information, beliefs, behaviors and even technology beyond their intended audiences. In this case, the unintended audience was young, unmarried women.

BACKGROUND

This study by the Department of Population Planning and International Health at the University of Michigan looked at the effects of family planning on women's status in Bangladesh. Data was collected from 36 focus groups in Matlab, Bangladesh, where the Family Planning and Health Services Project had been underway for ten years. The study resulted in two separate papers, one dealing with the effect of family planning fieldworkers on the knowledge and attitudes of young, unmarried women towards fertility and family planning; and the second reflecting on the relative importance of demand-side and supply-side factors in the fertility decline in Bangladesh.

FINDINGS

Program effects on young women

□ The Matlab family planning program inadvertently reached girls and unmarried young women, introducing the culture of contraception as a part of their normal process of socialization.

□ During a time when family planning information was not widely available to young girls, the home visits of family planning workers stimulated a growing awareness of the concept and meaning of family planning among the daughters of the workers' clients.

□ Family planning workers provided a new role model for young women and served as an example of female mobility, employment, modern dress and reproductive decision making.

Shamiran's Story

SHAMIRAN was so excited that she came out of the room and went to her aunt, saying, "We have seen what Mukti's Ma said to you and gave you. We know the story." The aunt said: "Well, since you came to know already, listen; those medicines are for controlling childbirth. If you do not want any more children, then you can have those. When you will want another child, then stop using those medicines and you can have the baby. You should not discuss these with anybody. When you will be married off, Mukti's Ma ... or I will tell you OK? No more questioning. Go."

Shamiran was amazed at her discovery. She went to Bani and explained everything. Bani said: "You should not say all those things. I feel shy." But Shamiran and Bani continued to discuss the topic several times. Shamiran said: "I think Mukti's Ma is doing a good job. I will have those medicines when I will be married off." Bani said: "How dare you talk like that before marriage?" But Shamiran replied: "I think you should also think about these medicines, because you are going to get married soon."

Then Shamiran went to school and discussed everything with the other young girls of the village.

Source: Simmons et al., 1994

□ Young girls discussed the family planning worker's activities with their friends before and after marriage. These discussions provided an important mechanism for the diffusion of knowledge about sexuality and contraception.

Qualitative analysis of the decline in fertility

□ The decline in fertility has multiple determinants. While the presence of a strong family planning program is a major contributing factor, many social and economic aspects of these women's lives are being transformed. Together these changes explain the interest in family limitation and spacing.

□ Women perceive that the cost of living is increasing generally, and they are concerned about the rising cost of providing for their children's needs, especially beyond the basic necessities of food and clothing. Their interest in "investing" in educating their children, both boys and girls, is increasing.

□ An important social factor in fertility decline is women's changing position in society. The authoritarian role of parents and in-laws is weakening, conjugal bonds are stronger, and young women are gaining a new degree of influence. The freedom to delay the onset of childbearing is a central element in this change.

□ Women often view the Matlab family planning worker as a trusted friend they can rely on to help them overcome fear of contraceptive methods and mediate disputes about family planning with relatives.

□ Women are aware of the many social and economic changes going on around them and are conscious and deliberate actors in the fertility transition. Program agents and the media help them to escape pre-established cultural scripts.

UTILIZATION OF RESULTS

□ The papers produced by this study are contributing to a better understanding of the mechanisms behind fertility transition and successful family planning programs. The first paper from this study, "Diffusion of the Culture of Contraception: Program Effects on Young Women in Rural Bangladesh," was published in *Studies in Family Planning* (January/February 1995).

□ The second paper, "Women's Lives in Transition: A Qualitative Analysis of the Fertility Decline in Bangladesh," was presented at the annual meeting of the Population Association of America. In this manner, the study's message--the importance of family planning workers in the diffusion of information about family planning and models of small families--was disseminated to a large audience of academics and program managers.

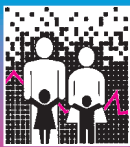
□ Both papers have been incorporated in the research utilization process in Bangladesh sponsored by the Ministry of Health and Family Welfare.

Simmons, Ruth, and Rezina Mita. 1995. Women's Status and Family Planning in Bangladesh: An Analysis of Focus Group Data. Dhaka: University of Michigan and the Population Council.

For further information on this study or to obtain a copy of the final report, please contact the Population Council, House CES(B) 21, Road 118, Gulshan Dhaka, Bangladesh. Tel: 880-2-883-127/881-227, Fax: 880-2-883-127.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

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CONFIRMING THE EXTENT OF FEMALE GENITAL MUTILATION (FGM)

Female genital mutilation (FGM) is an embedded cultural practice in Egypt, where 93 percent of women in this study were found to have some form of FGM. Study findings suggest that increased efforts to inform women and their families of the problems associated with FGM, especially cases of severe health complications or mortality, are needed to help discourage the practice.

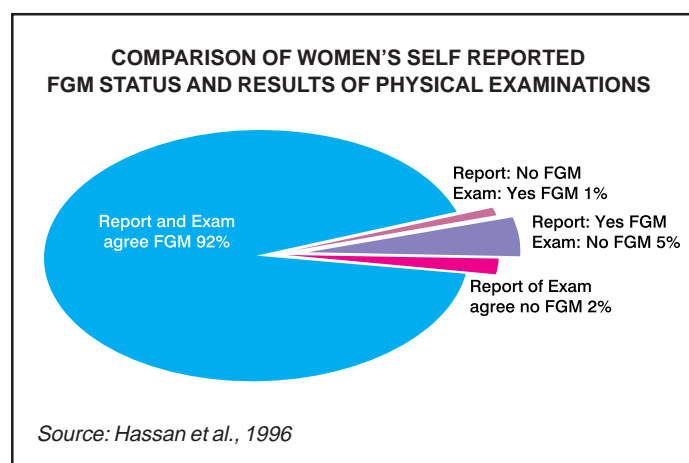
BACKGROUND

The 1995 Egyptian Demographic and Health Survey (EDHS) was the first nationally representative survey to measure female genital mutilation (FGM), which is performed mainly on pre-adolescent girls and involves the partial or total excision of external parts of the genital tract (labia minora, labia majora and clitoris). The study data indicated an FGM prevalence of 97 percent among Egyptian women of reproductive age. FGM is considered to mark a girl's passage to womanhood or her preparation for marriage. Negative health implications of the practice include death from hemorrhage, infection or tetanus; infertility; incontinence; and complications during pregnancy and childbirth. The Egyptian Fertility Care Society (EFCS), with support from Macro International and the Population Council's ANE OR/TA Project, carried out a clinic-based study to investigate the types of FGM practices in Egypt as well as the accuracy of the EDHS self-reporting. A total of 1,339 women selected at the out-patient services of 11 clinics providing gynecological or family planning services participated in the study. The women were interviewed using the FGM module from the 1995 EDHS. A specially-trained OB/GYN physician then conducted a physical examination to collect data on the prevalence and type of FGM.

FINDINGS

□ Self-reporting of FGM and the examination findings concurred in approximately 94 percent of cases. In all, 93 percent of the women were found to have some type of FGM.

□ Approximately 60 percent of the women examined were found to have partial or total removal of both the clitoris and labia minora; 17 percent had their clitoris removed; 7 percent had the labia minora excised; 9 percent had the tissue of the labia majora excised; and 7 percent showed no evidence of FGM.



□ The women included in the study are predominantly from lower socio-economic segments of Egyptian society as women from higher classes are less likely to utilize public health services for their health care.

□ Sixty-six percent of the women interviewed are below age 35, 95 percent are Muslim, all have been married, 64 percent were married below age 20, 35 percent have four or more children, 44 percent have no formal education, and 55 percent live in rural areas.

□ The likelihood for a woman to have some type of FGM decreases if her husband or either of her parents, particularly her mother, have a higher education.

□ Partial or total excision of only the clitoris was more prevalent among women between 15 and 24 years of age.

□ Eighty percent of all women in this study think that FGM should continue. Meanwhile, 94 percent of women with FGM intend to do the operation on their daughters as opposed to 64 percent with no FGM. Almost 40 percent of women with daughters cited custom as the main reason for this practice.

□ Among women who do not intend to practice FGM on a daughter, 59 percent said the practice was unacceptable and 40 percent feared complications.

□ Fourteen percent of women stated that FGM should be stopped. Of those, 43 percent view it as a bad custom, 42 percent fear the risk of complications, and 22 percent confirmed it prevents satisfaction with marital relations. Almost 80 percent of them emphasized educating parents on the hazards of the operation and 25 percent suggested banning the operation as a possible means of abolishing the practice.

□ Sixty-five percent of mothers had the procedure performed by a traditional midwife, as opposed to only 31 percent of daughters. A physician performed the operation on 10 percent of mothers and 37 percent of daughters.

UTILIZATION OF RESULTS

□ The study's findings have been incorporated in the final report of the 1995 Egyptian Demographic and Health Survey.

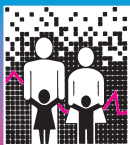
□ The findings are contributing to the scientific understanding of the practice of female genital mutilation in Egypt.

□ The national NGO task force on FGM is using the findings to develop a media advocacy plan and develop key public messages. This plan aims at suggesting and implementing tools that strengthen political support, educate media professionals about FGM hazards, and create a network of media professionals interested in covering the issue. The task force is also developing future research priorities.

Hassan, E.O., N.El Nahal, M. El Husseinie, F. Gamil, F. El Zanaty, A. Way, D. Huntington and L. Nawar. Clinic-based Investigation of the Typology and Self-reporting of FGM in Egypt, Final Report. 1996. Cairo: Egyptian Fertility Care Society, the Population Council, and Macro International. November.

For further information on this study or to obtain a copy of the final report, please contact the Egyptian Fertility Care Society (EFCS), 2A Mahrouki St., Monadesen, Cairo, Egypt. Tel 20-2-347-0674, Fax: 20-2-346-8782. Or the Population Council, 6A Giza Street, P.O. Box 115, Dokki, 12211 Egypt. Tel: 20-2-573-8277/570-1733, Fax: 20-2-570-1804.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery. Funding was also provided through Macro International's Demographic and Health Survey.



VOLUNTEERS PROVE SUCCESSFUL AT INCREASING MEN'S KNOWLEDGE OF FP

This project demonstrated that male involvement in reproductive health in rural Honduras can be increased through a fairly simple, low cost strategy adapted from successful, on-going agricultural extension strategies.

BACKGROUND

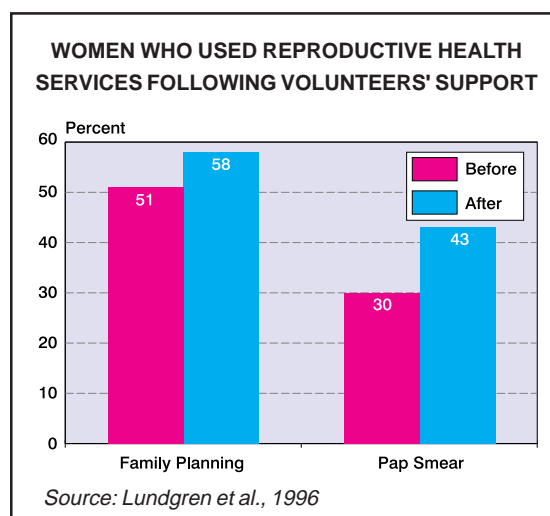
In rural Honduras, men believe they should play a major role in reproductive decision making, but have limited family planning knowledge. CARE, Honduras, with technical assistance from the Population Council's INOPAL Project, tested two strategies to increase male knowledge and involvement in family planning and reproductive health in rural Honduras. Both were based on CARE's experience with agricultural improvement projects. In the first strategy, CARE trained paid agricultural extensionists to provide reproductive health education in ongoing meetings with farmers and cooperative members using a manual which includes participatory activities and questions to stimulate reflection and discussion.

The second strategy, based on the Farm Management Plan utilized in Latin America by CARE to assist farmers to conduct strategic planning, designed an interactive family management booklet to help rural couples assess the resources and needs of their families and work together to develop a vision of their long term goals and how to achieve them. While filling out the booklet, which was designed for use by semi-literate individuals, couples reflect on the size of their family and the timing of their children. Both interventions included involvement by community volunteers. Most were small farmers and entrepreneurs who had successfully adopted farm management interventions or established small businesses who became actively involved in disseminating reproductive health education to other community members.

FINDINGS

□ Among non-pregnant women, the percentage of current users of family planning increased from 51 percent to 58 percent. The percentage who requested having a pap smear increased from 30 percent to 43 percent.

□ The percentage of women who reported having spoken to their partners about family planning in the last fifteen days increased from 36 percent to 50 percent. The percentage who had spoken with their partners about STDs or HIV increased from 42 percent to 54 percent.



□ Paid agricultural extensionists had serious reservations about providing reproductive health education, even after training. The focus group results demonstrated that community members were much more open to reproductive health education than were the extensionists.

□ Baseline survey data showed that only some of the men reached by this project had more than a sixth grade education. Their mean age was 37 years, and all were small land holders.

□ Men were enthusiastic about receiving reproductive health information. They would like the extensionists to dedicate more time to reproductive health during their meetings and would like to participate in training exclusively dedicated to the topic.

□ Community volunteers were enthusiastic about the program and did not require extra training. Many said it was the most valuable community activity they had participated in and asked for additional programs in reproductive health and sexuality.

□ In general, both volunteers and community members felt capable of providing reproductive health education themselves, and did not feel it was necessary to involve the extensionists. The time constraints imposed by the extensionist's regular duties did not leave much time for the new activity.

□ Simple interactive materials were culturally acceptable and were more popular than the more elaborate program of focus groups and meetings run by extensionists.

UTILIZATION OF RESULTS

□ Preliminary results led the Government of the Netherlands to provide funds to continue the project through July 1998 in the original project area.

□ CARE is using the materials developed under the project in its programs in Peru and Bolivia.

□ CARE is developing a strategy to scale up the intervention in the new five year extension of their agricultural extension project.

□ The Man to Man model for reproductive health is being replicated by an agricultural extension NGO in Mindanao, Philippines.

Why is family planning important?

Extensionists

"Improve the level of life."

"Food security."

"We can't keep thinking in terms of a sick family."

Community Members

"To live better and educate our children."

"To feed the children better."

"To protect the health of mothers and children."

Source: Lundgren et al., 1996

Lundgren, Rebecka and Dolores Valmana. 1996. Strategies to Involve Men in Reproductive Health Care: From Farm Management to Family Management. Tegucigalpa: PACO/CARE Honduras and the Population Council. December.

For further information or to obtain a copy of the final report, please contact Population Council, Residencial Casavola No. 37, Area Bancatlan, Miraflores, Tegucigalpa, Honduras, Tel/Fax: 504-32-60-21.

This project was supported by the Population Council's INOPAL III Project. INOPAL III is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-C-OO-95-00007-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

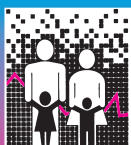
YOUTH



Shari Kessler (ANE OR/TA Project)

About half the world's population is under 25 years of age. Increasing urbanization in developing countries, among other social factors, is fostering early sexual activity among **youth**. Early sexual activity is associated with increased health risks: pregnancy, abortion, HIV/AIDS, and gender violence. Most young couples also need information to make better decisions about pregnancy and parenting. Providing accessible, quality family planning and reproductive health information and services to **youth** is critical for their own health and the well being of their families.

Operations research on **youth** has focused on understanding young people's perspectives on reproductive health issues, developing cost-effective education programs for **youth** that promote sexual responsibility, and designing services that are more **youth**-friendly.



STRENGTHENING NGOS PROVIDING REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENTS

The Government of Botswana is encouraging NGOs to play an active role in providing reproductive health services to adolescents. The program summarized here led to creation of an NGO network and the strengthening of the members' management and research capabilities to work with Botswana youth.

BACKGROUND

As part of an overall effort by the Government of Botswana to enhance the role of the non-governmental sector in health and social service provision, the Population Council's Africa OR/TA Project has supported the development and strengthening of a formal network of eleven NGOs which address the reproductive health needs of adolescents. This effort had a two-pronged strategy: the Botswana National Productivity Centre (BNPC), a local parastatal management training and consulting organization, assisted the NGOs to identify and address organizational and managerial issues; while the Health Research Unit (HRU) of the Ministry of Health provided training and technical assistance to the NGOs in how to use operations research (OR) to improve the delivery of reproductive health services.

FINDINGS

□ To meet a need identified during the project's Kick-off Workshop, the Botswana Council of NGOs (BOCONGO) created a database linked to a Geographic Information System (GIS) with information on most Botswana NGOs and maps showing the locale and activities of the Youth Education Project NGOs and registered members of BOCONGO.

OR studies implemented by the Youth Empowerment Project (YEP) Network BOTSWANA

- Assessing the Coverage and Adequacy of Services Provided by AMMB to Care Givers of HIV/AIDS Positive Youth
- Effectiveness of Peer Education Training Programs in Gaborone
- Accessibility, Availability and Use of Condoms among Youth
- Utilization of Information, Education and Communication Materials (IEC) on HIV/AIDS by Adolescents with Disabilities

Source: Montsi et al., 1997

□ At the two training workshops on operations research led by HRU, eight NGOs collaborated in development of four small-scale OR studies to diagnose or evaluate their service delivery problems.

□ At a series of retreats facilitated by BNPC staff, the NGOs identified factors that had the potential to promote or retard organizational performance. These retreats formed the basis for a tailored program of technical assistance to each organization and for design of management training workshops which covered strategic planning, change management, and time management.

UTILIZATION OF RESULTS

□ The Botswana Red Cross Society is using OR study recommendations to address factors which have limited the availability, suitability, and accessibility of IEC materials on HIV/AIDS for youth with disabilities.

□ The Botswana Family Welfare Association, based on recommendations to strengthen its teen peer education training program, developed a refresher course for peer educators. The NGO is also using its new research skills to evaluate and re-introduce a Family Life Education training program for primary school teachers.

□ The findings of a study on condom use and safe sex among youth led the Botswana Scouts Association to begin work on the development of a scout's curriculum on reproductive health education for youth.

□ As a result of the study by the Association of Medical Missions for Botswana (AMMB) on home care for youth with HIV/AIDS, an existing but outstanding proposal to introduce a hospice in one of the AMMB sites was reviewed and approved. The AMMB also approved recommendations to streamline activities and strengthen its home care program.

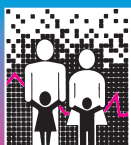
□ Collaboration on workshop and OR activities, and development of the GIS network has facilitated collaboration, networking, and information exchange among NGOs, the government and donor agencies.

Montsi, Mercy and Naomi Rutenberg. 1997. The Youth Empowerment Project: Strengthening NGOs Management and Service Delivery Capabilities in Botswana. Nairobi: the Population Council. June.

For more information or to obtain a copy of the report, please contact the Africa OR/TA Project II, Population Council, P.O. Box 17643, Nairobi, Kenya. Tel: (254) (2) 713-480; Fax: (254) (2) 713-479; E-mail: ORTA@popcouncil.or.ke.

This project was supported by the Population Council's Africa Operations Research and Technical Assistance (OR/TA) Project II. The Africa OR/TA Project II is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-3030-C-00-3008-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

January 1998



Youth

EXAMINING AWARENESS OF REPRODUCTIVE HEALTH ISSUES AMONG YOUTH

This descriptive study identified several areas where attitudes and social norms of Ghana's youth may be substantial barriers to their reproductive health (RH). They are eager for discussion of RH issues and assistance with their RH concerns.

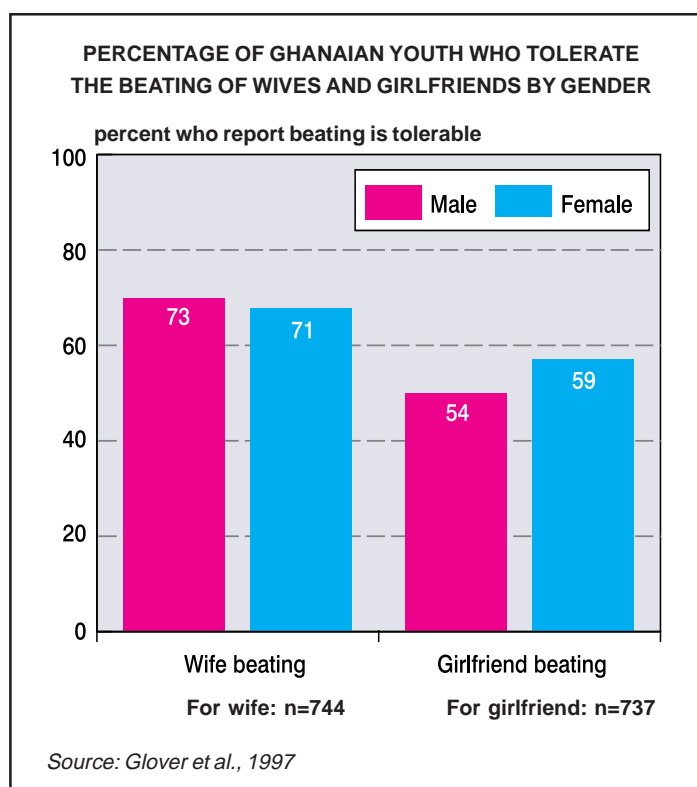
BACKGROUND

In preparation for planning a large project on sexual health for youth in the Volta Region, the Planned Parenthood Association of Ghana (PPAG) collaborated with the Population Council's Africa OR/TA Project on development of an instrument to elicit detailed descriptions of knowledge, behavior, and attitudes of Ghanaian youth on a wide array of reproductive health issues. Both as a pretest of this instrument and as a means of collecting baseline information for other new youth center activities, PPAG interviewed 250 youth aged 12-24 in each of three regional capital towns where new youth centers are planned. The stratified random samples contained in-school youth, out-of-school "organized" youth in apprenticeship programs, and youth selected from an "unorganized," out-of-school population.

FINDINGS

□ **Concerns:** Economic concerns about the lack of jobs and high clothing prices were paramount, especially for males. Although the lack of recreational facilities is one basis of the youth center initiative, this issue was of least concern to the respondents.

□ **Sexism and Violence Towards Women:** Respondents scored relatively high on a sexism scale. No significant differences were found by religion, age, or education. Seventy-two percent agree that there are "circumstances in which a husband can beat his wife." There are no differences between male and female responses on this issue.



□ **Sexual Intercourse:** More than half of the respondents claim to have had sexual intercourse, with a noticeable difference by age group. Less than 10 percent of youth aged 12 to 15, about 40 percent of those aged 16 to 17, and almost 75 percent aged 18 and over claim to have ever had sex. More females than males claim to have had sex in the 18 and over group. Almost all report their first sex partner was a boyfriend or girlfriend, playmate or classmate. They usually report a consensual first sexual encounter. Among those who have ever had sex, 69 percent of females and 35 percent of males report having only one partner in the last month. More males reported having either no partner, or two or more partners.

□ **Pregnancy:** Only 18 percent of the sample correctly indicate when, during the monthly cycle, pregnancy is most likely to occur. More than three-fourths say that there is nothing good about a teenage pregnancy. Thirty-four percent of never-married females who have ever had sexual intercourse indicate they have experienced a pregnancy; 91 percent of these say they did not want to be pregnant at the time; 89 percent of them had or attempted an abortion.

□ **Contraceptives:** Almost all claim knowledge of ways to avoid pregnancy. Methods mentioned most frequently are full abstinence, condoms, and oral contraceptives. Virtually all youth claim to have “heard of condoms,” but less than half mention each specific step of correct condom use. Sixty-one percent disagree that “it is OK for a young man to carry condoms in his pocket”, and 74 percent disagree that “it is OK for a young woman to carry condoms in her purse.”

□ **STI/HIV/AIDS:** Virtually all know of diseases one can get through sexual intercourse. Ninety-seven percent mention HIV/AIDS; 81 percent mention syphilis. Among respondents who have ever had sexual intercourse, 43 percent of males and 28 percent of females claim to have done something to avoid getting an STI in the last sexual encounter; 93 percent of these used a condom. Almost all indicate that AIDS is transmitted during sexual intercourse; only 11 percent incorrectly indicate that casual contact or insect bites are a source of HIV.

UTILIZATION OF RESULTS

□ Findings from this survey were used to improve the instrument that will be used in the larger Volta Region Project in 1997.

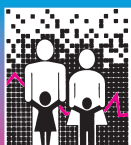
□ PPAG is using the findings to strengthen its strategies for several youth education programs. For example, based on the concerns expressed by youth, PPAG began to explore ways to incorporate more economic-related activities, such as job and apprenticeship counseling, into their youth center programs.

Glover, Kofi, Angela Bannerman, Robert Miller, et al. 1997. Adapting reproductive health strategies to adolescent needs: Findings from three Ghanaian towns. Accra: Planned Parenthood Association of Ghana and the Population Council, October.

For more information or to receive a copy of this report, please contact the Africa OR/TA Project II, Population Council, One Dag Hammarskjöld Plaza, New York, NY, 10017. Tel: (212) 339-0500; Fax: (212) 755-6052; E-Mail: pubinfo@popcouncil.org.

This project was supported by the Population Council's Africa Operations Research and Technical Assistance Project (OR/TA) Project II. The Africa OR/TA Project II is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-3030-C-3008-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

January 1998



FAMILY LIFE EDUCATION INCREASES CONTRACEPTIVE KNOWLEDGE AND USE BY MEXICAN YOUTH

In Mexico, an operations research project developed a family life education course that increased adolescents' reproductive health and family planning knowledge. The course was incorporated into the public school curriculum and also became the most widely used course in Mexican private schools. Replication has been successful in other Latin American countries, notably Peru and Bolivia.

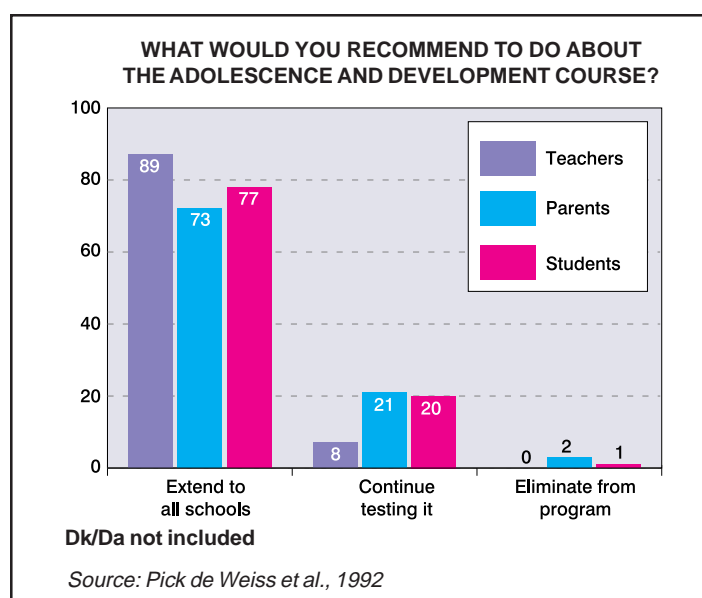
BACKGROUND

While fertility has declined among older women in Latin America, unwanted fertility remains high among adolescents. Survey data indicates that in most countries in the region, between 50 and 60 percent of unmarried women have had sexual intercourse by age 20, but have low levels of contraceptive use. Unmarried women with children suffer negative social and economic consequences from unintentional childbearing. In response to the problems of adolescent fertility in Mexico, the Population Council's INOPAL Project provided assistance to the *Instituto Mexicano de Investigacion de Familia y Población* (IMIFAP) and the Secretariat of Public Education (SEP) to conduct two studies in secondary schools in Mexico City that tested the impact and acceptability of a reproductive health and sex education course called "Planeando Tu Vida" (*Planning Your Life*). Course contents included reproductive anatomy and physiology, sexuality, contraception and sexually transmitted infections. In the first study, students in two schools were randomly assigned to treatment and control groups. The experimental group studied the *Planning Your Life* course. The control group received no formal sex education in school. The second study replicated the first in 88 schools and gathered parent and teacher opinions about the course.

FINDINGS

□ Parents, teachers, and students were overwhelmingly in favor of including the course in the national secondary school curriculum.

□ The cost of the course was modest. It was estimated that the cost of offering the course throughout Mexico would be as low as US \$1.36 per student.



□ Students receiving the *Planning Your Life* course had more contraceptive knowledge than students who did not. The course increased the proportion of students who could name at least one contraceptive method from 40 to 80 percent, and produced a positive change in the experimental groups' attitude toward contraceptive use.

□ Experimental group students who took the course were no more likely to become sexually active than controls who did not take the course. However, sexually active experimental group students were more likely to use contraceptives than sexually active controls.

UTILIZATION OF RESULTS

□ The Ministry of Education contracted IMIFAP to adapt the *Planning Your Life* course for inclusion into existing primary and secondary school curricula. About 50 percent of the original contents were included in the national secondary school curriculum. The State of Coahuila added the course in its entirety to the curriculum. *Planning Your Life* was also widely adopted in private secondary schools; over 300 had adopted the course by 1994. A video based on the course was produced and shown repeatedly on Mexican TV.

□ The McArthur Foundation supported a training of trainers from institutions in seven Latin American countries (Peru, Bolivia, Honduras, Uruguay, Chile, Colombia and Mexico). Funding from the Packard Foundation and the Bergstrom Fund has allowed IMIFAP to provide in-country training where the replication of the curricula has been especially successful (Peru and Bolivia), as well as in other countries where the course is being replicated (the Dominican Republic, Nicaragua, Guatemala and El Salvador).

Pick de Weiss, Susan, J.C. Hernandez, M. Alvarez and R. Vernon. 1992. *An Operational Test to Institutionalize Family Life Education in Secondary Schools in Mexico*. Mexico, D.F.: Instituto Mexicano de Investigación en Familia y Población (IMIFAP) and the Population Council. November.

For more information or to receive a copy of this study, please contact Ricardo Vernon, Deputy Director, INOPAL III, Population Council. Escondida 110, Col. Villa Coyoacán, 04000, Mexico, D.F., Mexico, Tel: 52-5-659-8541, Fax: 52-5-554-1226, E-mail: rvernon@laneta.apc.org.

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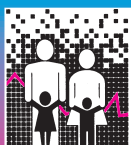
COST AND SUSTAINABILITY



Africa OR/TA Project

An understanding of the relationship between **cost and sustainability** is vital for policy makers and program managers as they seek ways to provide services and meet social goals using scarce financial resources. Operations research on **cost and sustainability** focuses on strengthening programs in three areas: cost control, income generation and cost recovery. Cost control entails using resources more efficiently, i.e., providing current services at a lower cost. Income generation refers to the provision of new services at a profit. Cost recovery refers to pricing services so that the income they generate covers the cost of providing them.

Operations research in **cost and sustainability** has focused on aspects related to the cost-effectiveness of programs, gathering data on the effect of price variation on the demand for selected reproductive health services, and determining the financial sustainability of service models.



EXAMINING COST, QUALITY AND SAFETY IN LABORATORY SERVICES

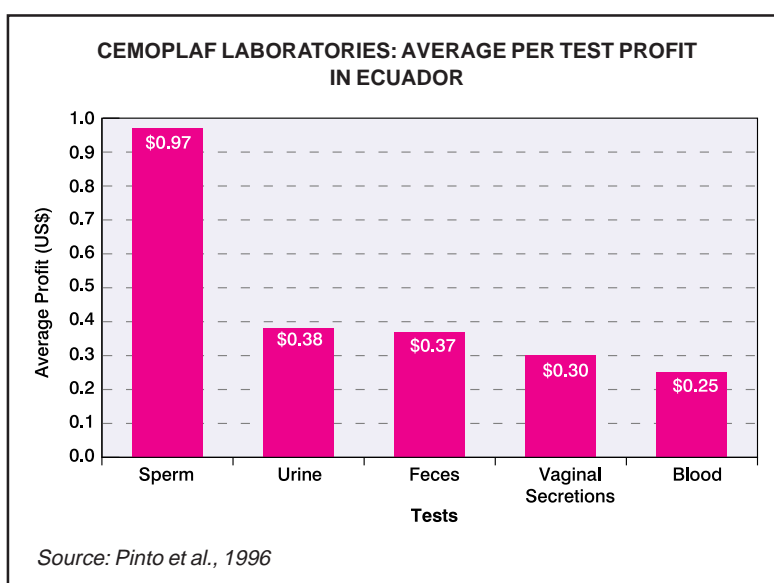
Providing laboratory services expands the reproductive health (RH) services an SDP can offer and is an effective strategy for generating program income. At the same time, laboratory services present new challenges which must be addressed through careful monitoring of costs, quality and safety.

BACKGROUND

CEMOPLAF, an NGO based in Quito, Ecuador, which began as a family planning organization, now provides a wide range of reproductive health and other services in twenty service delivery points (SDPs) and thirteen laboratories around the country. One of the NGO's priorities is to become 75 percent self-sufficient by 1997. Providing laboratory services is a key element of its sustainability and reproductive health care strategies. Currently, CEMOPLAF offers over 35 different laboratory services that examine blood, urine, vaginal discharges and feces at below market but still profitable prices. Basic RH tests include pap smears, STI (including chlamydia and HIV) and pregnancy tests, as well as more general exams such as cholesterol, triglycerides, and parasites. CEMOPLAF, with assistance from the Population Council's INOPAL Project and Family Health International (FHI), studied its laboratories to determine their profitability, quality, and safety. Eight of the agency's 13 laboratories were selected for study. Over 2,800 different tests were observed, an average of approximately 175 per technician.

FINDINGS

□ The study confirmed the high profitability of laboratory services as an income generating reproductive health service. The sampled laboratories all operated at a net profit of between 13 and 77 percent. Average profit was approximately 47 percent. Male fertility tests were the most profitable, yielding a profit of almost one dollar per test. Other tests yielded profits of 25 to 38 cents per test.



□ The most common quality problem detected was over or under-use of supplies such as reagents and fixatives in the preparation of samples. The observer noted and corrected the problems before the end of the observation session.

□ The most serious safety hazards were the practice of pipetting by mouth and a lack of vaccination protection among workers.

Implications of Findings

□ Sale of laboratory services, even at less than full market price, can contribute to financial sustainability while making these services more accessible to low income groups. Since laboratory services can be profitably integrated with family planning, the CEMOPLAF experience demonstrates that integration of family planning with other reproductive health services can be financially advantageous.

□ The study also suggests that the move away from stand-alone family planning programs to integrated reproductive health services confronts many organizations with a new challenge: developing the skills needed to monitor the costs, quality and safety of laboratories.

UTILIZATION OF RESULTS

□ CEMOPLAF used the results to improve quality control and safety procedures.

□ CEMOPLAF plans refresher training in testing procedures for all laboratory staff.

□ Manually operated pipets have been purchased for all laboratories, and all staff were inoculated against hepatitis.

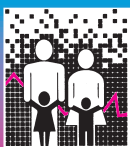
□ This study designed an innovative methodology to simultaneously capture cost, quality and safety factors. CEMOPLAF is developing plans to market its research services to the large number of commercial and not-for-profit laboratories throughout Latin America.

Pinto, Ernesto, Rosa Espín, Sonia Fabara, and Rocío Martínez. 1996. Investigación Operativa: Estudio de Costo y Generación de Ingresos en Laboratorios de CEMOPLAF. Quito: CEMOPLAF and the Population Council.

For more information or to receive a copy of the report, please contact Jim Foreit, Director, INOPAL III, Population Council, 4201 Connecticut Ave, NW, Suite 408, Washington, DC 20008, USA, Tel: (202)237-6455, Fax: (202)237-6458, E-mail: inopal@pcdc.org.

This project was supported by the Population Council's INOPAL III Project. INOPAL III is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-C-00-95-00007-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery. This study was conducted under the Ecuador Buy-In, Contract No. CCP-3030-Q-00-5008-00.

January 1998



INCREASING PRICES WHILE MINIMIZING CLIENT LOSS

A study of the effect of price on demand for services (elasticity of demand) in Ecuador suggests that many family planning/reproductive health (FP/RH) organizations in Latin America have been setting the prices of their services unnecessarily low. Results suggest that price increases of 50 percent will only result in a 7 percent client loss.

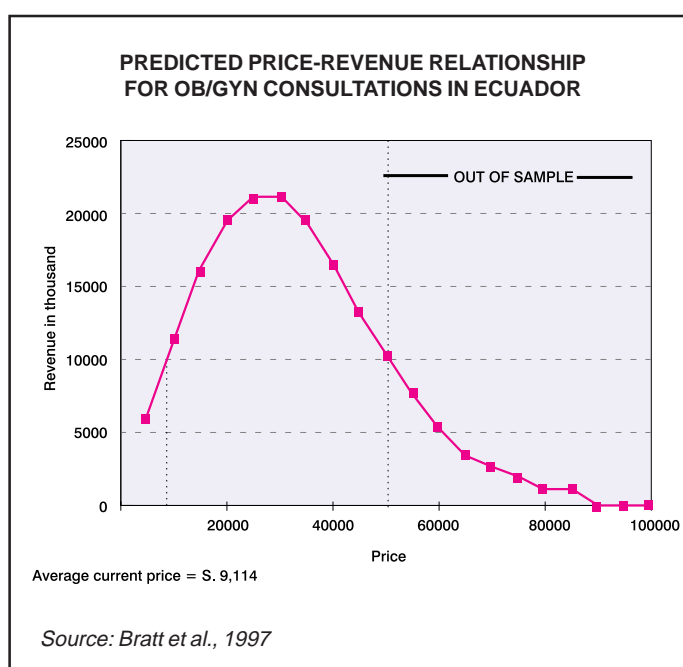
BACKGROUND

NGO reproductive health providers in Latin America face reductions in donor funding. The *Centro Medico de Orientacion y Planificacion Familiar* (CEMOPLAF) in collaboration with the Population Council's INOPAL Project, The Futures Group International (POLICY Project), and Family Health International, launched a price elasticity of demand (PED) study that tested a simple low cost survey methodology to measure consumer willingness-to-pay (WTP) for FP/RH services. The study also determined the price elasticity of demand for CEMOPLAF's services; and helped the organization understand how it might recover costs and increase financial sustainability while minimizing the loss of poor clients. Most clients who could not afford CEMOPLAF's prices would have to rely on Ministry of Health services. In the first stage, the study interviewed 5,000 clients to determine their ability to pay for services and their willingness to pay a hypothetical increase for a given service. The study then measured client reaction to three levels of price increases at three groups of service delivery points (SDPs), and compared this data with that of the survey.

FINDINGS

□ At the time of the survey, the average price that CEMOPLAF charged for an OB/GYN consultation was about US\$4 (Sucre 9,114). The price range for a consultation among all SDPs was between \$2 and \$10.

□ The predicted price-revenue relationship for OB/GYN services shows that raising prices within the Sucre 5,000 to 10,000 range (US \$2-10), will yield higher revenues because the price increment will offset any corresponding decline in utilization.



□ Over 80 percent of the survey respondents expressed a willingness to pay prices that were, on average, 50 percent higher than current service prices. Over half were willing to accept prices that were double what they were currently paying. These acceptance rates are consistent across the different services offered at the SDPs.

□ The study found that a CEMOPLAF clinic that charges \$4 for an OB/GYN consultation could raise prices to the revenue maximizing \$10, thus increasing revenues by 85 percent, but would lose over a quarter of its clients as a result. Raising prices and increasing revenue by 40 percent, however, leads to a loss of only 7 percent of users.

Implications of Findings

□ At the extremes, a program can set prices either to maximize revenue or minimize client loss. Between these two extremes, however, are a multitude of other prices, each associated with a different degree of client loss and revenue increase. Using information from price-revenue and price-utilization relationships, program managers can compare revenue increments and client losses associated with each pricing option available to them and make pricing decisions that balance the multiple objectives of their organization.

UTILIZATION OF RESULTS

□ The project continues to investigate whether client responses to survey questions administered prior to the increase reliably predict the price elasticity of demand (PED) for FP/RH services.

□ CEMOPLAF is convoking a meeting of SDP managers to discuss project results and set price increases.

□ APROFE, Ecuador's largest NGO service provider, will replicate the study in its SDPs.

Bratt, John, Jim Foreit, and Dan Kress. 1997. Price Elasticity of Demand for Reproductive Health Care in Ecuador. Quito: CEMOPLAF, Family Health International, The Futures Group International, and the Population Council.

For more information or to receive a copy of the report, please contact Jim Foreit, Director, INOPAL III, Population Council, 4201 Connecticut Ave, NW, Suite 408, Washington, DC 20008, USA, Tel: (202)237-6455, Fax: (202)237-6458, E-mail: inopal@pcdc.org.

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January 1998



REDUCING COSTS AND INCREASING PROFITS IN MINI-PHARMACIES

This study identifies a number of factors, including inventory, location, and staffing costs, which affect the profitability of mini-pharmacies operating in CEMOPLAF's service delivery points (SDPs) in Ecuador. Mini-pharmacy managers are using study results to increase profitability and reduce costs.

BACKGROUND

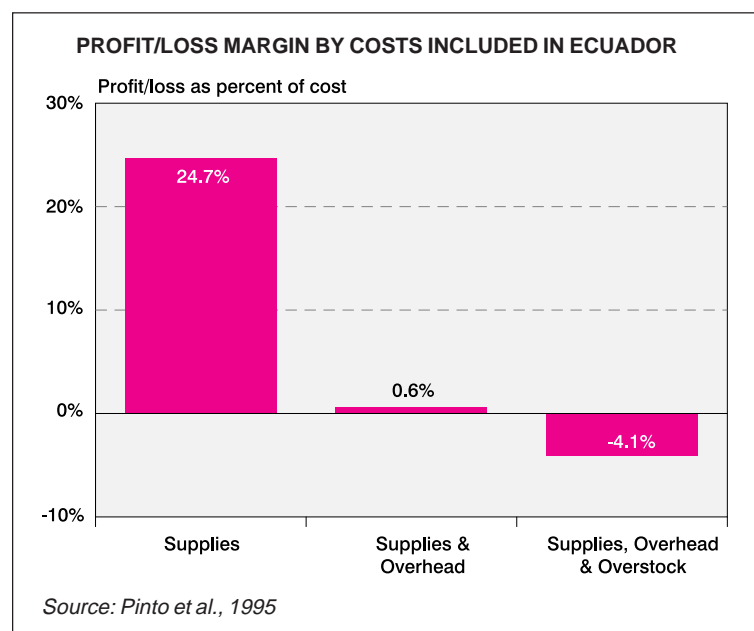
As part of sustainability activities, 16 CEMOPLAF clinics opened mini-pharmacies ("Botiquines") to sell medications at slightly less than commercial pharmacy prices, but at a price higher than product cost. Local managers make all decisions related to mini-pharmacies, including their location, product line, and selection of wholesaler. Although they are open to the general public, the majority of clients are CEMOPLAF patients, because the pharmacies are located inside the SDP. CEMOPLAF, with assistance from the Population Council's INOPAL Project and Family Health International (FHI), conducted a study of 13 mini-pharmacies to identify factors contributing to their profit or loss. All 13 had been operating a minimum of one year. Cost and income data were examined for the first six months of 1995.

FINDINGS

Overstock

□ Overstock was the managerial factor that most affected variation in profits (losses). Supplies that were sold generated a profit of 24.7 percent versus their costs. The cost of supplies plus overhead versus income from sales suggests mini-pharmacies more or less break even (0.6 percent profit). When the cost of overstock is included in the calculation, however, the mini-pharmacy results in a loss of close to 4 percent.

□ Mini-pharmacies mainly stocked items prescribed to clients using CEMOPLAF services. Eleven of the thirteen mini-pharmacies were overstocked on at least one item, and the value of overstock ranged from between US\$9 and US\$174.



- Levels of excess inventory ranged from less than one month supply to several years at current sales levels.
- If overstock were eliminated, the current monthly loss would be reduced by 21 percent. Reducing inventory below three-month levels would further decrease losses.
- The maximum amount of monthly overstock that a clinic may have on hand and still break even is US\$4 worth of overstock. Every additional dollar in inventory over the US\$4 cut off point increases monthly loss by 23 percent.

Profitability

- Average monthly sales in all 13 mini-pharmacies during the study period were US\$18,560. Average monthly costs were estimated at US\$19,525, resulting in an average monthly loss of US\$965, or almost 5 percent. Only three mini-pharmacies made profits (between 2.5 and 2.6 percent per month). Losses in the remaining mini-pharmacies ranged from less than 1 percent to over 27 percent.
- Fixed costs averaged 20 percent of income. Only mini-pharmacies where fixed costs were less than 20 percent of income were profitable. Salaries were the largest fixed cost element, accounting for over 64 percent of total fixed costs.

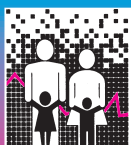
UTILIZATION OF RESULTS

- Based on study results, some clinics are working to increase their profitability by reducing mini-pharmacy staff, and all clinics began reducing inventory.
- Managers are attempting to improve income generation by adding higher profit product lines on a trial basis and selling them at current market prices.

Pinto, Ernesto, John Bratt, Carlos Rivas, Fanny Simbaña, Ana Ilbay, Maria Rosa Garate, and James Foreit. 1995. Investigacion Operativa: Generacion de Costos e Ingresos en Mini Farmacias. Quito: CEMOPLAF, Family Health International and the Population Council. June.

For more information or to receive a copy of the report, please contact Krishna Roy, Program Manager, INOPAL III, Population Council, 4201 Connecticut Ave, NW, Suite 408, Washington, DC 200008, USA, Tel: (202)237-6455, Fax: (202)237-6458, E-mail: inopal@pcdc.org.

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PRODUCTIVITY AND PAYMENT OF VOLUNTEER WORKERS

This study found little relationship between productivity and payment for health service referrals by traditional birth attendants (“matrones”) in Haiti. Expansion of the matrone training and referral program does not provide for payment for these volunteer workers.

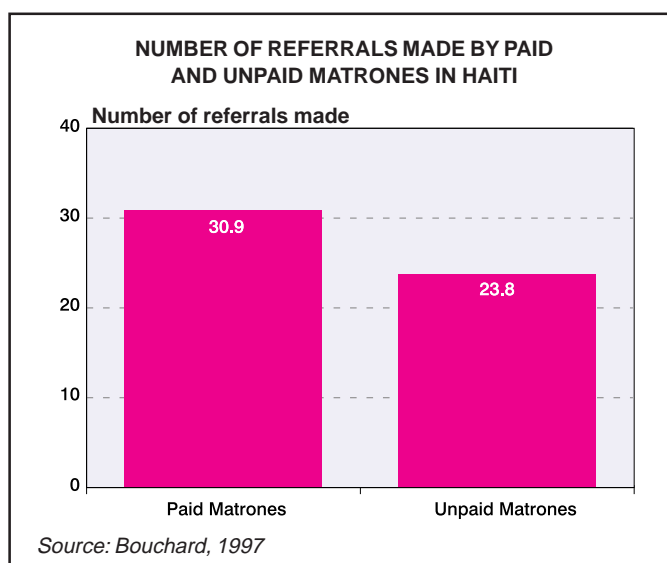
BACKGROUND

The *Comité de Bienfaisance de Pignon* (CBP) provides health services, including perinatal services using traditional birth attendants (“matrones”), to a population of 150,000 in five rural communities in Haiti, where 90 percent of women deliver at home. Matrones usually help with births and are also a source of perinatal care. To increase use of health services, CBP trained ten matrones in one community in perinatal care, birthing, referral of high risk pregnancies, breastfeeding, and family planning and paid them 600 Gourds (US\$40) per month to refer women for perinatal and postpartum family planning services to health centers. The perinatal service was successful, but upon deciding to expand the program into two additional communities, limited funds forced re-examination of the payment policy. With the goal of examining the relationship between productivity and payment of these traditionally volunteer workers, CBP, with technical assistance from the Population Council’s INOPAL Project, carried out two studies. The first study examined the impact of reducing matrone payment by 50 percent in the original project community. The second study was conducted in two new villages and compared the productivity of paid and unpaid matrones. The new groups of matrones received training, and each community received a health post. In one new community, the matrones received a US\$20 per month stipend, in the other, the matrones received no stipend.

FINDINGS

Decreasing the Stipend

- The pay cut did not lower matrone referral output compared to the pre-pay cut period.
- Combined mean referrals by matrones equaled 20.2 per month, with great variability. Referrals by individual matrones for both periods ranged from one every five months to more than twelve per month.



□ No reliable difference was found between the total number of pre- and postnatal visits to CBP services during the months when matrones received a full payment and when that payment was reduced.

Comparing Paid and Unpaid Matrones

□ There was no reliable difference in total prenatal visits per month between the two communities.

□ Matrones who were paid US\$20 per month made more referrals (30.9 vs. 23.8) than unpaid matrones, but the difference in the number of referrals did not translate into a higher total number of health center visits in the community with paid workers. In both communities, worker referrals resulted in an average 53 visits per month.

□ The marginal cost per referral in the experimental commune was estimated at US\$28.57.

Implications of Findings

□ In rural Haiti other factors, such as access to professional and para-professional health care providers and health centers, may be more important to program success than the extent to which matrones are paid.

□ Payment affects matrones' activities. However, matrone productivity does not appear to be strongly related to the level of payment. This lack of relationship between payment and productivity may result in part from the fact that the population covered by a matrone in rural Haiti is limited, and thus greater effort cannot result in proportionally greater output.

□ Non-professional payment should be linked to performance. Initial payments should be relatively low, and should increase with productivity.

UTILIZATION OF RESULTS

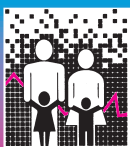
□ CBP has eliminated matrone payments in all communes, but the organization continues to train traditional birth attendants and integrate them into perinatal activities.

Bouchard, Glen. 1997. Model Postpartum Program for Rural Populations in Haiti. Port au Prince: Comité de Bienfaisance de Pignon and the Population Council.

For more information or to receive a copy of the report, please contact Jim Foreit, Director, INOPAL III, Population Council, 4201 Connecticut Ave, NW, Suite 408, Washington, DC 20008, USA, Tel: (202)237-6455, Fax: (202)237-6458, E-mail: inopal@pcdc.org.

This project was supported with funding from the Population Council's INOPAL III Project. INOPAL III is funded by the U.S. Agency for International Development (USAID), Office of Population, under contract No. CCP-C-OO-95-00007-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery, and Cooperative Agreement No. 521-0189-00-4019-00.

January 1998



INCREASING PRICES WHILE MINIMIZING CLIENT LOSS

A study of the effect of price on demand for services (elasticity of demand) in Ecuador suggests that many family planning/reproductive health (FP/RH) organizations in Latin America have been setting the prices of their services unnecessarily low. Results suggest that price increases of 50 percent will only result in a 7 percent client loss.

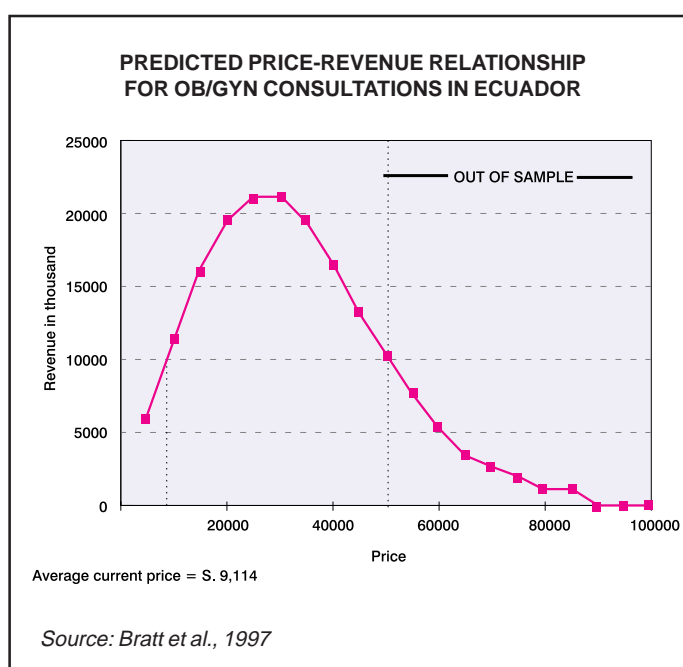
BACKGROUND

NGO reproductive health providers in Latin America face reductions in donor funding. The *Centro Medico de Orientacion y Planificacion Familiar* (CEMOPLAF) in collaboration with the Population Council's INOPAL Project, The Futures Group International (POLICY Project), and Family Health International, launched a price elasticity of demand (PED) study that tested a simple low cost survey methodology to measure consumer willingness-to-pay (WTP) for FP/RH services. The study also determined the price elasticity of demand for CEMOPLAF's services; and helped the organization understand how it might recover costs and increase financial sustainability while minimizing the loss of poor clients. Most clients who could not afford CEMOPLAF's prices would have to rely on Ministry of Health services. In the first stage, the study interviewed 5,000 clients to determine their ability to pay for services and their willingness to pay a hypothetical increase for a given service. The study then measured client reaction to three levels of price increases at three groups of service delivery points (SDPs), and compared this data with that of the survey.

FINDINGS

□ At the time of the survey, the average price that CEMOPLAF charged for an OB/GYN consultation was about US\$4 (Sucre 9,114). The price range for a consultation among all SDPs was between \$2 and \$10.

□ The predicted price-revenue relationship for OB/GYN services shows that raising prices within the Sucre 5,000 to 10,000 range (US \$2-10), will yield higher revenues because the price increment will offset any corresponding decline in utilization.



□ Over 80 percent of the survey respondents expressed a willingness to pay prices that were, on average, 50 percent higher than current service prices. Over half were willing to accept prices that were double what they were currently paying. These acceptance rates are consistent across the different services offered at the SDPs.

□ The study found that a CEMOPLAF clinic that charges \$4 for an OB/GYN consultation could raise prices to the revenue maximizing \$10, thus increasing revenues by 85 percent, but would lose over a quarter of its clients as a result. Raising prices and increasing revenue by 40 percent, however, leads to a loss of only 7 percent of users.

Implications of Findings

□ At the extremes, a program can set prices either to maximize revenue or minimize client loss. Between these two extremes, however, are a multitude of other prices, each associated with a different degree of client loss and revenue increase. Using information from price-revenue and price-utilization relationships, program managers can compare revenue increments and client losses associated with each pricing option available to them and make pricing decisions that balance the multiple objectives of their organization.

UTILIZATION OF RESULTS

□ The project continues to investigate whether client responses to survey questions administered prior to the increase reliably predict the price elasticity of demand (PED) for FP/RH services.

□ CEMOPLAF is convoking a meeting of SDP managers to discuss project results and set price increases.

□ APROFE, Ecuador's largest NGO service provider, will replicate the study in its SDPs.

Bratt, John, Jim Foreit, and Dan Kress. 1997. Price Elasticity of Demand for Reproductive Health Care in Ecuador. Quito: CEMOPLAF, Family Health International, The Futures Group International, and the Population Council.

For more information or to receive a copy of the report, please contact Jim Foreit, Director, INOPAL III, Population Council, 4201 Connecticut Ave, NW, Suite 408, Washington, DC 20008, USA, Tel: (202)237-6455, Fax: (202)237-6458, E-mail: inopal@pcdc.org.

This project was supported by the Population Council's INOPAL III Project. INOPAL III is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-C-OO-95-00007-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery and The Futures Group International Policy Project, funded under USAID Cooperative Agreement No. CCP-3078-C-00-5023-00. Additional funding was provided under Family Health International's Contraceptive Technology and Family Planning Research Program, Cooperative Agreement No. CCP-3079-A-00-5022-00.

January 1998

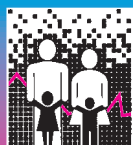
INSTITUTIONALIZATION OF OR



Africa OR/TA Project

The ability of family planning and reproductive health organizations to design, carry out, and use the results of OR is essential for improving the effectiveness of the services they provide. Thus, one objective of the OR process has been to strengthen and **institutionalize** the research, dissemination, and utilization process.

Efforts toward the **institutionalization of OR** have focused on strategies to strengthen the capacity of public, NGO, and private service programs and research institutions to conduct and use OR; to improve the methodologies used in health systems research; and to assist managers to incorporate OR into routine planning and management procedures. Studies have also been conducted on the dissemination and use of OR results for policy and program development.



OPERATIONS RESEARCH UTILIZED FOR REVIEW OF POPULATION POLICY

The review of population policy priorities in Bangladesh has led to an increase in the utilization of existing research for policy and better focused investments in future research to respond to the government's strategic needs for information.

BACKGROUND

The Population Council was requested by the Office of Population and Health, USAID/Dhaka to prepare a background study for the "Policy Dialogue and Implementation Plan for the USAID Family Planning and Health Services Project". With the cooperation of the University Research Corporation Bangladesh (URCB), the Council reviewed selected population and family planning issues of concern to the Government of Bangladesh and developed a policy implementation plan to address the identified problems. URCB collected relevant policy documents of the Government of Bangladesh, interviewed knowledgeable public officials regarding the history of and rationale for these policies, and determined the degree of compliance with official policy through investigation and observation both centrally and in the field.

FINDINGS

□ The adversarial relationship between medical and non-medical personnel in the Family Planning Wing of the Ministry of Health and Family Welfare impedes program implementation. To address this problem, the posts of thana family planning officers (TFPOs) and medical officers (MOs) should be regularized, and MOs guaranteed career mobility. In addition, TFPOs should be provided with better office and living space, MOs should not receive sterilization fees, and MOs should have disbursing authority over clinic-related FP/MCH matters.

□ Further research is needed to find a suitable way to shift family planning workers from the Development to the Revenue Budget, which would increase their job security and retirement benefits, without constraining the ability of the government to change the structure of the program.

Priority Policy Areas

1. Relationships between non-medical and medical personnel in the FP wing of MOHFW
2. Status of FP staff funded under the development budget
3. Training of FP and MCH personnel
4. Coordination of government and NGO efforts
5. Urban health and FP
6. Pricing, cost recovery and sustainability
7. Integration of Health and FP programs
8. Managerial accountability
9. Program management information system
10. Incentives by type of contraceptive method

Source: Barkat-e-Khuda et al., 1994

- To address the deficiencies in the training received by FP/MCH personnel, the comparative advantages in the training capacity of the government, NGOs, and the private sector should be determined and a national training program developed.
- Efforts to coordinate the activities of the government and NGO community should be continued.
- A status review of urban family planning is needed before an effective policy dialogue can begin.
- Because of efforts to increase the sustainability of the FP/MCH program, cost recovery is becoming an increasingly important issue. Although free services and supplies contribute to the cost of the program, the real obstacle to sustainability is the recurrent costs of the intensive community-based distribution system.
- Integration of the family planning and maternal and child health programs is still weak. A clearer delineation of roles and the provision of adequate training, supplies, and supervision of workers could reduce the potential for conflict.
- Program inefficiencies result from confusion about job descriptions, poor supervision, and low worker productivity. Greater managerial accountability is crucial to attempts to implement reforms to improve the quality and coverage of the FP system.
- The program's management information system suffers from irregular reporting, inaccurate data and a lack of personnel with adequate skills to interpret available results. Thus, insufficient use is made of available information.
- A balance must be reached between factors favouring the use of clinical methods of contraception and the provision of high quality care, including the distribution of a wide variety of family planning methods.

UTILIZATION OF RESULTS

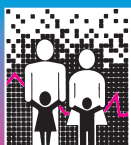
- This report was part of a larger effort to systematically analyze, review, and discuss the climate for population policy in Bangladesh. Although the impact of the country's family planning programs has been remarkable, with contraceptive prevalence doubling from about 23 percent in the early 1980s to 45 percent in 1994, continued progress will be based on the ability to learn from past experience and adapt to changing contexts.
- In June 1994, the government established a National Steering Committee (NSC) to address future challenges in FP/MCH program. The Population Council is working with the NSC as the lead technical support agency. This careful analysis of the current situation in ten key areas gave policy makers an overview of program status and suggested ways in which the program should evolve in the future.

Barkat-e-Khuda, Abul Barkat, Javed Helali, Peter Miller, and John Haaga. 1994. Population Policy In Bangladesh: A Review of Ten Priority Areas. Dhaka: University Research Corporation (Bangladesh) and the Population Council.

For further information on this study or to obtain a copy of the final report, please contact the Population Council, House CES(B) 21, Road 118, Gulshan Dhaka, Bangladesh. Tel: 880-2-883-127/881-227, Fax: 880-2-883-127

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development, Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

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INSTITUTIONALIZING OPERATIONS RESEARCH

In Latin America, institutionalization of the ability to conduct operations research (OR) in service delivery and research organizations means that organizations now conduct operations research studies and/or utilize results without outside technical assistance or funding.

BACKGROUND

Operations research is a continuous process that helps service delivery organizations adapt to a constantly changing environment. Institutionalization of OR in service delivery and research organizations contributes to the longterm sustainability of reproductive health programs and activities and, ultimately, improved quality of care. The Population Council's INOPAL OR/TA Project has found, in working to institutionalize operations research, that the process works at three levels: for small service organizations, for larger service delivery organizations, and for universities and other research organizations.

FINDINGS

Small Service Delivery Organizations

□ Participation in OR seminars: INOPAL has conducted many seminars in Latin America and the Caribbean (LAC) which explain OR and commonly used research techniques. Organizations also may participate in specialized seminars on topics like cost analysis or quality of care research. Numerous seminars have been conducted in Bolivia, Ecuador, Haiti, Honduras, Mexico, and Peru.

□ Collaboration on OR projects: Many small organizations have conducted one or more OR projects with INOPAL assistance. These projects familiarize managers with using data for decision making, provide computer equipment and software, and train staff to gather and interpret data.

□ Improvement of Management Information Systems (MIS): Timely and reliable routine data collection is an important factor facilitating the ability to conduct OR. Because small organizations do not have the resources required to undertake special studies, most OR is limited to analyses of routine data on program inputs and outputs. Often, MIS systems are created or improved as a part of OR activities.

Institutionalizing OR

- **For small service organizations,** institutionalization of OR means that the agency is capable of making decisions based on data.
- **For larger service delivery organizations,** institutionalization of OR means that the agency has the in-house capacity to conduct special studies on priority problems.
- **In universities and research organizations,** institutionalization of OR means that staff collaborate with service providers in conducting OR and provide students with training in applied research.

Source: Foreit, 1997

Larger Service Organizations

□ The institutionalization process for larger service delivery organizations, which often have their own resources, includes participation in OR seminars, collaborating on individual projects, and MIS development. However, the process for these large agencies also features longterm commitments with the specific objective of institutionalization.

□ In Ecuador, the INOPAL Project worked with CEMOPLAF, a non-governmental organization, for more than five years to institutionalize the capacity to conduct research on sustainability. The process consisted of training courses, extensive staff participation in six OR projects, and experience in proposal writing and results dissemination.

□ In Mexico, INOPAL helped institutionalize operations research at the state level in the Mexico Social Security System (IMSS) by holding seminars in which IMSS staff learned to design OR projects, the best of which were funded and whose results contributed to numerous programmatic changes.

Universities and research organizations

□ While institutionalization of OR in service delivery agencies is usually limited to mastering the techniques needed to conduct research, the institutionalization process in universities and research institutions involves staff and students with a wide range of interests and skills in the process of learning about and conducting applied research.

□ INOPAL projects have institutionalized OR in universities in both Mexico and Peru. The process included providing a library of OR-related materials, providing opportunities to conduct OR, and support for courses and seminars. In Mexico INOPAL also assisted the School of Public Health of the National Institute of Health (INSP) to conduct a market survey to determine the demand for a degree program in reproductive health containing a strong operations research component.

UTILIZATION OF RESULTS

□ CEMOPLAF can now write research proposals, conduct cost analyses, client and household surveys, and use market research tools without outside technical assistance. CEMOPLAF now attracts funds for OR from several donors and conducts projects with its own resources.

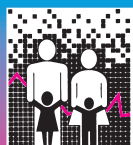
□ IMSS continues to conduct in-house OR seminars and project design competitions, using its own resources. OR study results have contributed to many programmatic changes.

□ In Peru, students at the School of Public Health of Cayetano Heredia University can receive support for theses on OR topics.

For more information, please contact Jim Foreit, Director, INOPAL III, Population Council, 4201 Connecticut Ave, NW, Suite 408, Washington, DC 20008, USA, Tel: (202)237-6455, Fax: (202)237-6458, E-mail: inopal@pcdc.org.

This activity was supported by the Population Council's INOPAL III Project. INOPAL III is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-C-OO-95-00007-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

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INSTITUTIONALIZING OR IN THE MEXICAN SOCIAL SECURITY INSTITUTE FOR GOVERNMENT WORKERS (ISSSTE)

ISSSTE tested an innovative strategy to institutionalize operations research by having service providers propose, design and implement operations research (OR) activities in their service sites. Results are already being used to improve provision of reproductive health (RH) services.

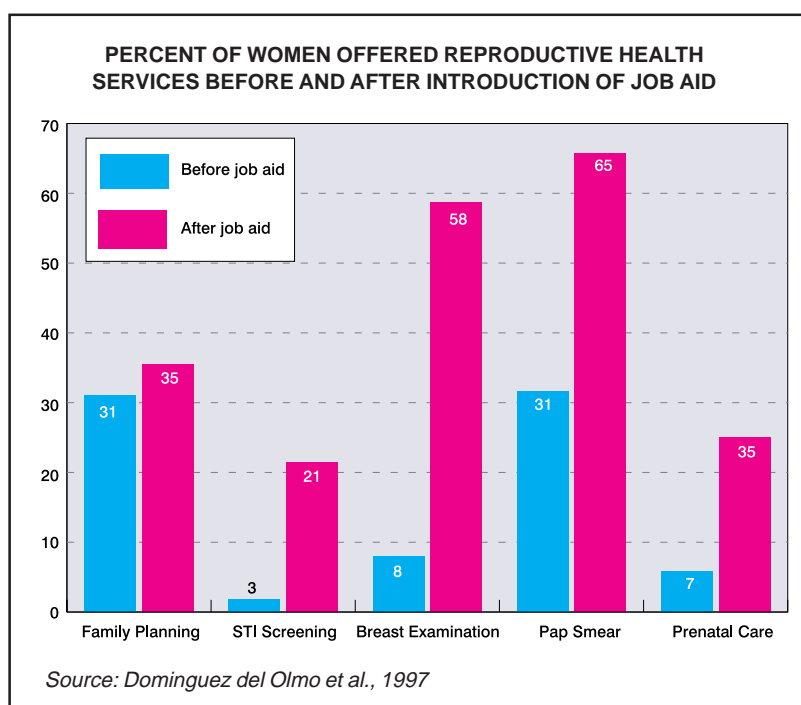
BACKGROUND

In Mexico, nine million people receive health care services from ISSSTE, the social security program for government workers and their dependents. ISSSTE health sector resources include 36,000 employees and almost 1,200 service delivery points located throughout Mexico. At a program review in 1995, the Reproductive Health Director of ISSSTE proposed establishing an in-house OR capacity based on studies conducted by physicians in family practice training. Four teams were invited to a seminar to learn more about OR and to prepare their proposals. Four \$5,000 grants were awarded to implement the projects. Two projects were successfully completed by June 1997, and another is still underway. The first tested the use of an algorithm, or job aid, to identify women with unmet need for reproductive health services. The second developed a strategy to decrease the incidence of Cesarean section births (C-sections) at an ISSSTE hospital in the city of Guanajuato.

FINDINGS

Identifying women with unmet need for RH services

Most women request only a single health service when they visit an ISSSTE facility, even though they may require several services. Providers used an algorithm to identify client needs for RH services in addition to the service requested by the patient. The study produced a large improvement in screening and use of RH services.



The incidence of C-Sections

□ Prior to the study, C-sections accounted for 50 percent of all deliveries at an ISSSTE hospital in the city of Guanajuato. Thirty-one percent of women having C-sections were giving birth to their first child, 18 percent were giving birth to at least their second child but had never had a C-section, 34 percent had had one previous C-section, and 17 percent had two or more.

□ Fifty-seven percent of the women giving birth to at least their second child were told that they needed a C-section because they had had a previous C-section, and 37 percent were given no explanation for the procedure.

□ Although 94 percent of women had received education during prenatal classes, 77 percent received no information about C-sections.

□ A survey of physicians found that 74 percent were insufficiently familiar with C-section norms. Doctors attributed the high incidence of C-sections to poor patient screening, lack of provider time and fear of lawsuits.

UTILIZATION OF RESULTS

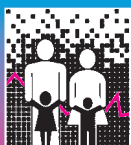
□ In order to increase participation in development and implementation of OR studies, ISSSTE has decided to design projects centrally and circulate them among health care facility staff. Facilities deciding to participate as study sites are being provided with the resources and training needed to conduct the projects.

□ ISSSTE has used the data from the C-section study to design a strategy to reduce the number of C-sections performed at ISSSTE hospitals. The strategy includes providing prenatal education about the procedure; establishing clear guidelines for physicians; training staff in the guidelines; and establishing a system for monitoring compliance.

Dominguez del Olmo, Javier, Marco Antonio Olaya, Francisco Javier Gomez Glavenlina and Ricardo Vernon. 1997. Using Operations Research to Solve Reproductive Health Problems. Mexico City: Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado (ISSSTE), National Autonomous University of Mexico (UNAM), and the Population Council. June.

For more information or to receive a copy of the report, please contact Ricardo Vernon, Deputy Director, INOPAL III, Population Council. Escondida 110, Col. Villa Coyoacan, 04000, Mexico, D.F., Mexico, Tel: 52-5-659-8541, Fax: 52-5-554-1226, E-mail: rvernon@laneta.apc.org.

This project was supported by the Population Council's INOPAL III Project. INOPAL III is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. CCP-C-OO-95-00007-00, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.



INCREASING UTILIZATION OF OPERATION RESEARCH RESULTS

Operations research (OR) has been integral to the development of a mature, quality-oriented national family planning program in Indonesia. Greater cooperation among researchers and family planning managers in the selection of topics, research design, and improved dissemination of research results has increased utilization and the impact of OR findings.

BACKGROUND

For the past seven years, operations research has been the heart of USAID support to Indonesia through the Population Council's ANE OR/TA Project in collaboration with the Center for Biomedical and Human Reproductive Research (PUBIO) of the National Family Planning Coordinating Board (BKKBN) studied the utilization of findings and recommendations from 26 completed OR studies implemented between 1988 and 1995 with funding from USAID, the World Bank, the Asian Development Bank and UNFPA. The study looked at the contribution of the research to country-specific needs, research quality, applicability of the findings, simplicity of the research tools, cost-effectiveness of recommendations, dissemination of results, and the extent to which utilization of results has been realized. A total of 38 BKKBN officials working at different administrative levels were interviewed.

FINDINGS

- The majority of respondents felt that OR is useful in supporting on-going FP program improvement.
- Studies recognized as having program impact include research on self-sufficient family planning, research concerning the role of rural midwives in Lampung, the NORPLANT® use dynamic study, and the Situation Analysis of government service delivery points.
- OR is seen as impacting BKKBN IEC and training programs in particular.
- When OR findings and recommendations are presented in a timely manner at pre-existing decision-making forums, chances for utilization increase.

Respondent's Observations on OR Utilization

"If data is accurate and informative, OR is quite useful for planning, solving problems, and suggesting strategies."

"The program has already started when the research results appeared."

"Dissemination of results should be more comprehensive."

"OR on self-sufficient family planning became a national policy."

Source: Iskandar et al., 1996

- Simple research designs and strategies increase the likelihood that the results will be understood and recommendations implemented.
- Replication or scaling up of an OR activity in additional provinces is viewed as evidence of 'high cost-effectiveness' and an indication that the recommendations will result in changes in policies, programs or interventions.
- The respondents felt that research should better address the major FP program and policy constraints; most wanted researchers to carry out multi-disciplinary studies that can provide more comprehensive answers to operations questions raised.
- Recommendations from research were often perceived as unclear, lacking in utility, or a restatement of the problem; utility of recommendations decreased when they called for additional study rather than offering a plan for problem solution.
- Middle-managers expressed interest in learning more about OR methods and use, to better interpret OR findings and participate more effectively in OR discussions.
- Many middle-managers said that their input is rarely sought in the OR planning stage, but admitted that they seldom invite researchers to participate in discussions of programmatic problems.
- Research results presented in a variety of formats (e.g. using visual aids, simple messages, non-technical jargon and presented in a brief form) increases utilization. When results are presented in a format that is not easily readable, they are often ignored.

Implications of Findings

- Involving policy makers and program managers from the beginning of the OR process gives them a sense of ownership in the research and increases the policy relevance of the findings. Dissemination of OR findings and recommendations should be directed toward policy makers at the provincial as well as the central level.

UTILIZATION OF RESULTS

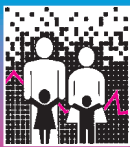
- BKKBN is incorporating efforts toward increasing the OR utilization capacity of BKKBN researchers, program managers and policy makers into the annual program planning via regular workshops, seminars, and research summaries.
- The BKKBN Bureau of Information and Documentation Network (BIJID) requested technical assistance on producing readable, attractive summaries of research reports to be circulated among policy makers and program managers at the provincial and central levels.

Iskandar, Meiwi B. and Subadra Indrawati. Indonesia: Utilization of Completed Operations Research Studies, Final Report. 1996. Jakarta: National Family Planning Coordinating Board (BKKBN), Training and Development Center for Biomedical and Human Reproduction; and the Population Council. November.

For further information or to obtain a copy of the final report, please contact Population Council, Tifa Building, Suite 404, Jl. Kuningan Barat No. 26, Jakarta, Indonesia 12710. Tel: 62-21-520-0094, 520-0494, Fax: 62-21-520-0232.

This project was conducted with support from the Population Council's Asia and Near East Operations Research and Technical Assistance Project. The ANE OR/TA Project is funded by the U.S. Agency for International Development (USAID), Office of Population, under Contract No. DPE-C-00-90-0002-10, Project No. 936-3030, Strategies for Improving Family Planning and Reproductive Health Service Delivery.

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MAKING OPERATIONS RESEARCH A PART OF PROGRAM MANAGEMENT

Much has been accomplished in institutionalizing OR for decision making in the Philippines by bringing together local program managers and researchers to identify issues, develop and implement OR to address them, draw up action plans based on findings and incorporate effective longer term follow-up.

BACKGROUND

The Family Planning Operations Research and Training Program (FPOR TP) of the Philippines was established in October 1992 to strengthen the national capacity to carry out and utilize operations research for FP program planning and management of service delivery by Local Government Units (LGUs). Two training workshops brought together 35 family planning program managers and researchers to discuss program constraints, prioritize issues, explain the concepts, techniques and usefulness of operations research, and prepare research and funding proposals. Researchers then implemented five OR projects, endorsed by the Department of Health and funded by FPOR TP, in close collaboration with local program managers. Findings were disseminated and implications for operations discussed in local and national workshops with participants from government agencies, NGOs, health service and academic institutions. This study reviewed the experience of FPOR TP and other agencies in order to assess the factors affecting utilization of OR outputs in the country's health and FP programs.

FINDINGS

- Tasks that need to be undertaken to institutionalize operations research for decision making revolve around creating and sustaining the demand for OR, developing and maintaining local research capacity, and establishing mechanisms that promote the interaction of program managers and researchers.
- In three years, much has been accomplished in bringing together local program managers and researchers to identify priority issues, develop and implement operations research to address these issues, and draw up action plans based on research findings.

OR Planning and Management: Challenges of Devolution

With the devolution of delivery of health and family planning services to LGUs, new realities emerge in the process of institutionalizing OR-based program planning and management:

- The priority given to FP and research varies greatly among LGUs.
- The capabilities of local program managers to initiate, undertake and utilize research vary greatly.
- Operations problems requiring research often manifest themselves at the lowest level of decision making, where the initiative and capability for undertaking research are often lacking.
- The dynamics of planning and budgeting vary greatly among LGUs and are influenced by people and institutions outside the LGU.

Source: Herrin, 1995

- The amount of operations research undertaken and utilized will depend upon the interaction of demand (program managers) and supply (researchers).
- Factors important to utilization include: 1) relevance of the research to the concerns of the program manager, 2) recommendations that can be acted on directly, 3) recommendations that fall within the decision-making authority of the program manager, and 4) the program manager's ability to interpret research results and incorporate these results into decision making.
- Under FPORTP, there was a strong feeling among both program managers and researchers that the effects of the actions taken should be evaluated, again jointly by researchers and program managers. The broader implication is that longer term evaluation and follow-up of the action program should become part of the OR process, and as such, planned for and funded.
- As completed studies accumulate, findings should be synthesized and transformed into a consistent set of recommendations for other LGUs.
- Personnel at all levels of health service management and delivery in the Philippines need skills for managing OR, to ensure that the various stages of the OR process take place as planned, culminating in improved planning and management. Skills are also needed for mobilizing resources for research.

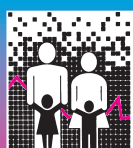
UTILIZATION OF RESULTS

- Under FPORTP, research findings were quickly utilized. For example, a study of factors affecting the performance of volunteer workers in the delivery of FP services in Iloilo City found that they needed training in motivating and communicating with clients. Thus, the City Government trained the volunteers in community organization and basic family planning.
- In Bukidnon province, the findings on quality of care, logistics, supervision and IEC for husbands led to full utilization of FP clinical standards by service providers, who now use the manual as a guide in their daily clinic operations. The province has now put in place a logistics system and intensified supervision to include on-the-job training. Program reviews conducted with local government units uncovered additional problems, and steps for improvement have been initiated.
- The Population Council is working closely with the DOH and Management Services for Health to bring the lessons learned to all LGUs.
- To further enhance utilization, the OR program is strengthening links to the Essential National Health Research Unit and other research programs.

Herrin, Alejandro N. 1995. Operations Research for Program Planning and Management, Final Report. Manila: School of Economics, University of the Philippines and the Population Council. November.

For further information on this study or to obtain a copy of the final report, please contact the Population Council, Monteverde Mansions#17, 85 Xavier Street, Green Hills, San Juan, Metro Manila, Philippines. Tel: 63-2-722-6886, Fax: 63-2-721-2786.

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DISSEMINATION OF SITUATION ANALYSIS FINDINGS INCREASES UTILIZATION

Disseminating the results of a national Situation Analysis (SA) study to program managers and service providers at the regional level enabled them to identify the weaknesses and strengths of their programs and to improve the quality of the service they provide.

BACKGROUND

In 1994, the National Family Planning Program (PNPF) of Senegal, with technical assistance from the Population Council's Africa OR/TA Project, conducted a Situation Analysis study of the family planning services provided at all 180 service delivery points (SDPs) in the country. Since the study included every SDP, it was possible to analyze the data separately for each of the country's ten regions, the level at which programmatic decisions about service delivery are made. A decentralized dissemination strategy was devised in which the data were analyzed by region, and a seminar was conducted in each region to present the results. Regional and district-level managers and providers developed recommendations for strengthening the regional program based on this information and produced ten region-specific reports.

FINDINGS

□ A large majority of districts felt that they could take responsibility for developing, managing, and implementing improvements in SDP functioning and service quality. They recognized, however, that regional and national level policies in certain areas would impact district functioning.

□ Regional staff are expected to prepare an annual Plan of Action, and for 1996 many of the recommendations made at these regional seminars were included in regional plans. Moreover, staff from the central level of the PNPF played an active role in this decentralized dissemination process, which contributed to a sense of ownership of the study's results at all levels of the program.

District Perceptions of District, Regional and National Responsibilities for Improving Quality of Care, Senegal			
Areas for Improvement	District	Regional	National
Interpersonal Relations	□		
Barriers to the Use of Contraceptives	□	□	
Choice of Methods	□	□	□
Information Given to Clients	□		□
Technical Competence	□		□
Mechanisms to Encourage Continuity	□	□	□
Source: Diop et al., 1995			

- District-level staff emphasized the need for placing more trained personnel at SDPs, and increasing the skills of current staff, perhaps through regular refresher training courses. They noted a strong need for training in IEC techniques and counseling, management, and supervision.
- Most staff called for more regular supervision – preferably once every two months, or quarterly – and emphasized the need to establish or improve their job descriptions, clarify their overall objectives, and develop a chronogram of family planning activities.
- Most districts expressed the need to have a greater variety of IEC materials on hand. Staff recommended that materials for a series of group health talks be developed, and that IEC leaflets be offered to women waiting for consultations.
- Clients visiting SDPs pay an “entrance fee” that gives them free access to all health services provided, including contraceptive methods. Results from the study indicated that providers are charging clients an additional fee for contraceptive methods, although they are supposed to be provided for free, and that such fees vary significantly by SDP. District-level managers commonly recommended that method prices be standardized.
- Most managers felt that clinic personnel must be encouraged to respect the official opening time of 7:30 A.M. in order to reduce client waiting time.
- Personnel revealed that they discouraged injectables because they thought they were associated with infertility, and requested training sessions in order to learn more about the method.
- Many seminar participants expressed a desire to improve their facilities by re-organizing the consultation and waiting areas.

Implication of Findings

- The study demonstrated remarkable differences between national and regional perceptions of the program’s strengths and weaknesses. The decentralized dissemination process proved an optimal way to encourage utilization of study results at all levels, and empowered individual program managers and providers to be inventive and enact changes in their own programs.

UTILIZATION OF RESULTS

- Regional staff included many of the recommendations made at dissemination seminars in their regional plans.
- Discussions at each regional seminar gave central PNPF staff an opportunity to learn more about their colleagues’ attitudes and expectations.
- PNPF central staff incorporated some of the regional recommendations into the 1996 National Plan of Action.

Diop, Marième, Isseu Touré, Nafissatou Diop, et al. Analyse Situationnelle du système de prestation de services de planification familiale au Sénégal. 1995. Dakar: National Family Planning Program, Ministry of Health and Social Action and the Population Council.

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